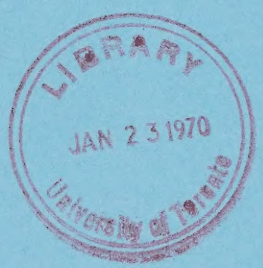
HEALTH AND WELFARE SERVICES

IN CANADA

1969



A publication of the Department of National Health and Welfare, Canada

HEALTH AND WELFARE SERVICES IN CANADA

1969

Research and Statistics Directorate

Published by authority of
the Honourable John Munro
Minister of National Health and Welfare

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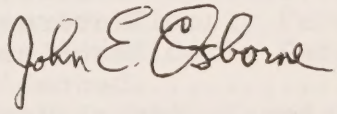
FOREWORD

This book gathers together for ready reference brief descriptions of arrangements made for the provision of health and welfare services to Canadians, resumés of recent events in the evolution of those arrangements, and pertinent statistics of their operation. Most of the contents were prepared by the Research and Statistics Directorate of the Department of National Health and Welfare for the chapter, "Health, Welfare and Social Security" of the 1969 Canada Year Book. Certain other material is included here that for brevity was omitted from that chapter. Material contributed to the Canada Year Book chapter by other agencies is not included.

The Directorate is indebted to many officers of the Department for contributing to various passages; the other sections were prepared by the staff of the Directorate. The editor was Mr. Arthur F. Smith, Supervisor of the Health Expenditure and Resources Section.



John E. Osborne,
Director,
Research and Statistics.

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INTRODUCTION

Among the significant developments of 1968 was the calling of the first International Conference of Ministers Responsible for Social Welfare which was held in New York in September under United Nations auspices. Canada's Minister of National Health and Welfare, the Hon. John Munro (who had succeeded the Hon. Allan J. MacEachen on July 5th) joined representatives of 93 other nations to ensure, in his words, "that the human and material resources of a country are effectively mobilized and developed to deal successfully with the social requirements of change".

Included in the Canadian Delegation to the Conference were the Hon. L.N. Theriault, Minister of Health and Welfare for New Brunswick; the Hon. J.B. Carroll, Minister of Welfare for Manitoba; the Hon. C.P. MacDonald, Minister of Welfare for Saskatchewan; and Mr. Roger Marier, Deputy Minister of Family and Social Welfare for Quebec. Of the four Commissions active during the Conference, that dealing with "Social Welfare Within The Context of National Development" was chaired by the Deputy Minister of National Welfare, Dr. Joseph W. Willard.

Another important task undertaken by Dr. Willard in the course of 1968 was the preparation of a review of Social Development Programs as a basis of a Government assessment of federal measures in this field. Existing programs and alternative options were examined as a part of this internal assessment.

A number of developments in Canada's social security system proved helpful from the viewpoint both of meeting the needs of individual Canadians and of relieving the provinces of costs which they have been, or would otherwise be, carrying. One of these developments was the further reduction in the age of eligibility for the Old Age Security pension and the Guaranteed Income Supplement. As of January 1st, 1969, people could qualify for these benefits at age 66 instead of 67. As a consequence, persons over 66 no longer require basic assistance under the shared-cost programs of Old Age Assistance, Blind Persons Allowances and Disabled Persons Allowances, and this meant a further significant saving to the provinces. When the process of reducing the eligibility age was begun in 1966, it was estimated that by the time the process was completed (i.e. January 1, 1970) the savings to the provinces over the four-year period would amount to some $120 million.

As for the impact of the Guaranteed Income Supplement program, an indication of what it has meant in terms of reducing the demand for provincial supplementary assistance can be gained from the fact that as of the end of 1968, 750,000 Old Age Security beneficiaries (i.e. more than one-half the total caseload) were receiving the Supplement, and of this number more than 450,000 were being paid the full amount available. In this connection, the further cost-of-living escalation of benefits effective January 1, 1969, brought the Old Age Security pension up to $78.00 a month and the combined maximum of the Old Age Security pension and the Guaranteed Income Supplement payment to $109.20 a month.

It is also worth noting that the Canada and Quebec Pension Plans have begun to make a significant contribution in the field of income maintenance. In February 1968, benefits for survivors were paid for the first time, and by year-end some 11,000 widows and orphans were receiving such benefits under the Canada Pension Plan alone. Many of these recipients would otherwise have had to depend for their basic maintenance on mothers' allowances or general assistance. Similarly, the retirement benefits, now payable at age 66, are increasingly significant. By the end of 1968, more than 37,000 persons were receiving such benefits which, as of January 1969, reached a maximum of $32.00 a month. (The maximum payment for persons retiring at the end of 1969 will be $42.00 a month).

During 1968, the Canada Assistance Plan completed its second year of operation and there was increasing evidence of its effectiveness not only in bringing together and improving existing public assistance programs, but also in integrating child welfare services, providing support for health services to persons in need, extending a wide range of administrative and welfare services, and making provision for Indian welfare and for work activity projects. With coverage under the Plan currently running at approximately one million recipients, federal payments for 1969-70 are estimated at close to $500 million.

In August 1968, a Task Force on Sport was appointed by the Minister of National Health and Welfare. This was composed of Mr. W. Harold Rea, Toronto, Chairman; Miss Nancy Greene, Rossland, B.C.; and Dr. Paul Desruisseaux, Quebec City. The Task Force is to study relationships between professional and amateur sport and between the Federal Government and the national and international sport-governing bodies. It is also to suggest ways in which the Federal Government can improve Canadian athletic competition at home and abroad.

On the health side, the outstanding event of 1968 was the coming into force of the National Medical Care Act. Effective July 1st, agreements came into effect between the Federal Government and the governments of Saskatchewan and British Columbia (see page 13). No other provinces entered into agreements in 1968, but several were reported planning to sign in 1969.

Because of the considerable growth in health care costs, a Federal-Provincial Committee was set up at a meeting of Ministers of Health of the Federal and Provincial Governments held in November in Ottawa. This Committee is to advise the Ministers concerning ways and means of keeping the cost of health services at a reasonable level. At the same Conference, the Federal Government announced its intention of phasing out certain parts of the General Health Grants Program over a three-year period. It also indicated its plans to cease financial participation in the Hospital Construction Grant in 1970, and to limit expenditure on the Health Resources Fund in 1968-69 to $37,540,000.

Much attention has been given to the augmentation of Canada's limited physical facilities and manpower resources for the provision of health care. Within the Federal Government, the Health Resources Directorate of the Health and Welfare Department is planning studies to measure needs and enhance the efficiency with which present resources are employed. The provinces have also been conducting studies and have been building health science centres. These centres, integrated complexes for the complete provision of all facets of health care, education, and research, are under construction or active planning in major cities across Canada; the Health Resources Fund has made major contributions to them (see page 14). In October, representatives of the centres and other interested professionals met in Ottawa, under the auspices of the Department of National Health and Welfare, in a session to discuss common problems and engage in an exchange of ideas.

Other events and circumstances of 1968 with special bearing upon health and social security included the following:

The growing problem of the abuse of drugs (narcotics, marijuana, LSD, STP, and modelling glue): the apparent failure of the established mechanisms of law enforcement to significantly curb, or even to slow down, the increase in the misuse of these substances, was leading to heightened concern and to increased demands for re-examination of the approaches made in the past. Two government bills were introduced in the Senate in 1968 to facilitate the control of hazardous substances and restricted drugs. These are now being considered. Concurrently, the Department has set up a Committee to examine the problem of drug abuse and to make recommendations to guide future policy.

Steadily increasing documentation of the harmful effects of smoking upon health: late in the year the Department of National Health and Welfare published a listing, by brand-name, of the nicotine and "tar" content of all cigarettes commonly sold in Canada. Six bills introduced in the House of Commons late in 1968 by private members were referred to Committee and not simply "talked out", as is often the fate of such bills. Moreover, their consideration by the Committee had the support of the Minister. Three of the bills would prohibit or regulate cigarette advertising, another would extend the Food and Drugs Act to tobacco products, yet another would require warnings of hazards to health to appear on tobacco packages, and one bill would limit the "tar" content and nicotine level permitted in cigarettes.

Water pollution studies: the boards set up in 1965 by the International Joint Commission of Canada and the United States to reduce the pollution of Lake Erie, Lake Ontario, and the international section of the St. Lawrence River submitted their second interim report to the governments in August 1968. In this report they outlined achievements to date, which were considerable, and set out the scope of remaining problems, namely: objectionable and harmful substances in the water; eutrophication(a); thermal pollution; disposal of radioactive wastes; and pesticide runoff from broad tracts of land.

The Department of National Health and Welfare submitted a brief to the Special Senate Committee on Science Policy in November 1968. The brief recommended that the department's scientific activities be adequately supported, that training and research into scientific administration be stressed, that survey standards be updated and applied, that an explicit science policy be adopted, that a scientific evaluation of educational systems in Canada be undertaken, that a research-information clearing-house be established, that there be a continuing parliamentary committee on science policy, that an ongoing Canada Health Survey be established, that social and behavioural science be represented on the Science Council of Canada, that the Federal Government's social research be co-ordinated, that a clearing-house be set up on Canada's international research activities, and that fundamental research be adequately supported.

(a) The enrichment of waters by nutrients, generally causing heavy growth of aquatic vegetation such as algae, which, by decaying, progressively exhaust dissolved oxygen in lower depths. The effect is cumulative; the results are marked and often surprising; and the dynamics are not fully understood.

PART I - PUBLIC HEALTH

Provincial governments bear the major responsibility for health services in Canada, with the municipality often assuming considerable authority over matters delegated to it by provincial legislation. The Federal Government has jurisdiction over a number of health matters of a national character and provides important financial assistance to provincial health and hospital services. All levels of government are aided and supported by a network of voluntary agencies working in different health fields.

Section 1 - Federal Health Activities

The Department of National Health and Welfare is the chief federal agency in health matters but important treatment programs are also administered by the Departments of Veterans Affairs and National Defence. The Dominion Bureau of Statistics is responsible for collection, analysis, and publication of national health statistics, the Medical Research Council and the Defence Research Board administer medical research programs, and the Canada Department of Agriculture has certain health responsibilities connected with food production.

The Department of National Health and Welfare is concerned with food and drugs, including narcotics, operates quarantine and immigration medical services, carries out international health obligations, and provides health services to Indians, Eskimos, and other special groups. It advises on medical aspects of eligibility of applicants for blindness allowances and co-operates with the provinces in the provision of surgical or remedial treatment for recipients of the allowances. Under the Public Works Health Act, supervision of health conditions is provided for persons employed on federal public works. Health counselling and medical supervision are provided for the federal Public Service. The Department also administers the civil aviation medical program for the Department of Transport.

Subsection 1 - Food and Drug Control

The provisions of the Food and Drugs Act, administered by the Food and Drug Directorate of the Department of National Health and Welfare, apply to the manufacture, advertising, packaging, and sale of foods, drugs, cosmetics, and medical

devices anywhere in Canada. Wide powers are given under this legislation to maintain the safety, purity, and quality of food and drug products and to prevent misrepresentation in labelling and advertising. The Act specifically prohibits the advertising of any food, drug, cosmetic, or medical device as a preventive or cure for a number of serious diseases and also lists drugs that may be sold only on prescription.

Standards of safety and purity are developed through laboratory research and maintained by means of a constant and widespread inspection. The inspection of food-manufacturing establishments plays a major role in the production of clean, wholesome foods containing ingredients that meet recognized standards. Changing food technology requires the development of methods of laboratory analysis to ensure the safety of new types of ingredients and packaging materials. The Food and Drug Regulations list chemical additives that may be used in foods, the amounts that may be added to each food, and the underlying reason. Information on new additives must be submitted for careful review before they are added to the permitted list. Considerable emphasis is placed upon studies to ensure that the levels of pesticide residues in foods do not constitute a health hazard. The effect of new packaging and processing techniques on the bacteria associated with food spoilage is also of special concern.

Detailed information on all new drugs must be reviewed by the Directorate to determine compliance with requirements before release for sale is permitted. Drug regulations set standards for drug manufacturing, facilities, and controls, and prescribe additional safeguards in the distribution of investigational and new drugs. Drug manufacturing requirements relate to sanitation of facilities, employment of qualified personnel, testing to ensure standards of quality and safety at stated stages of processing, and maintenance of records of testing performance, together with a system of control to enable a complete and rapid recall of any lot or batch of drugs from the market. The controls over clinical trials and marketing of new drugs require detailed information to be submitted to the Directorate concerning the method of manufacture, the tests applied to establish standards of safety and quality, and substantial evidence of the clinical effectiveness of the new drug for the purposes stated. Samples of the final product must also be submitted. Before carrying out clinical trials, a manufacturer also must file complete data on his experience with the drug including any evidence of adverse side effects, and the qualifications of the persons to be engaged in its investigational use. The Minister may suspend clinical testing based on this evidence if he feels that it is in the public interest to do so; in such case, the manufacturer has the right to appeal the decision.

The Food and Drug Directorate administers the Proprietary or Patent Medicine Act, which is concerned with the voluntary registration before marketing and the annual licensing of secret-formula medicines sold under proprietary or trade names.

The Directorate conducts an adverse-drug-reaction reporting program across Canada to recognize and investigate reactions to drugs. The co-operation of the medical, dental, veterinary, and pharmaceutical professions is also solicited in advising the Directorate of such reactions in private practice.

Since October 1966, every manufacturer and distributor of drugs in Canada is required to submit to the Food and Drug Directorate certain information on all products he is marketing in Canada other than products registered under the Proprietory or Patent Medicine Act. Notification must be sent to the Directorate each time he intends to market another product, make changes in existing products, or withdraw a product from the market.

Regulation of the supply and use of narcotic drugs is carried out under the Narcotic Control Act, as revised in 1961. This legislation, is administered by the Division of Narcotic Control of the Directorate. The Act is designed to ensure that narcotics, while readily available for their proper medical use, are not diverted from this use. The Royal Canadian Mounted Police and other law-enforcement agencies enforce the Act and seek to reduce the illicit traffic.

Subsection 2 - Medical Services

Through its Medical Services Branch, the Department of National Health and Welfare provides several direct and indirect types of medical service, as described in the following paragraphs. "Indirect" services are provided by hiring local services where practicable.

Indians and Eskimos. - Medical and public-health services are made available to registered Indians or Eskimos who are not included under provincial arrangements and who are unable to provide for themselves. Much of the service in treatment and health education is rendered to the patients through 34 departmental out-patient clinics and 85 health centres staffed by medical and other public health personnel. In remote areas, the key facility is frequently the departmental nursing station, a combined emergency treatment and public health unit usually having two to four beds under the direction of one or two nurses; 47 of these are operated throughout Canada.

Where practicable, there has been an increasing integration of Indians in provincial and municipal health agencies, so that the number of hospitals and other facilities provided specifically for them have been reduced accordingly. At present the Department maintains 14 hospitals at strategic points and co-operates elsewhere with community, mission, or company hospitals. Indians are included under all provincial prepaid insurance plans for hospital care and other forms of insured medical care. Indian and Eskimo health workers are trained to give instruction in health care and sanitation.

Northern health. - Because of the special problems in developing health services in the Far North, the Department has been given the responsibility of co-ordinating federal and territorial health care for all residents. In so doing, it undertakes the functions of a health department for the Council of the Northwest Territories and assists the government of the Yukon in the provision of certain health services. Hospital insurance plans are in effect in both territories.

In the Yukon, services for the total population, administered through the Commissioner for the Yukon and provided on a cost-sharing basis with the Department of National Health and Welfare, include complete treatment for tuberculosis, payment for services rendered at the Alberta cancer clinics, mental hospital care through arrangements with the province of British Columbia, and medical care for indigent patients. Public-health nursing services, measures for the control of communicable diseases, and administration of the principal public hospital are primarily the responsibility of the Department.

Similar services are provided in the Northwest Territories. The costs are shared between the territorial government and the Departments of National Health and Welfare and of Indian Affairs and Northern Development.

Sick mariners. - The Department provides compulsorily prepaid medical, surgical, hospital, and other treatment services to crew members of all foreign-going ships arriving in Canada and Canadian coastal vessels in interprovincial trade, and offers medical, surgical, and other treatment prepayment on an elective basis to crew members of Canadian fishing vessels. (Canadian seamen obtain their hospital care under the provincial hospital insurance plans.)

Quarantine. - Under the Quarantine Act, all vessels, aircraft, and other conveyances and their crew and passengers arriving in Canada from foreign countries are inspected by the quarantine officers to detect and correct conditions that could lead to the entry into Canada of such diseases as

smallpox, cholera, plague, yellow fever, typhus, and relapsing fever. Fully organized quarantine stations are located at all major seaports and airports.

Immigration. - Under the Immigration Act and the Department of National Health and Welfare Act, the Immigration Medical Service conducts in Canada and other countries the medical examination of all applicants for immigration to Canada and provides treatment for certain classes of persons after arrival in Canada, including immigrants who become ill en route to their destination or while seeking employment.

Public service health counselling. - Health counselling is offered through Medical Services Branch units to federal employees throughout the country. This service is primarily diagnostic and advisory only, but emergency treatment may also be given.

Civil aviation medical assessment service. - Air pilots and other air personnel are routinely examined by this service for physical and mental fitness for the performance of their duties.

Regulation of hygienic standards. - The Department is responsible for enforcing hygienic standards on federal property including ports and terminals, interprovincial means of transport, and on Canadian ships and aircraft.

Coast Guard medical service. - The Department provides a medical service for the Canadian Coast Guard.

Subsection 3 - Medical Research

Federal government agencies have steadily increased their funds allocated for both intramural and extramural biomedical research to $44.7 million in 1967-68. Funds designated in the Estimates for these purposes in 1968-69 totalled $53.5 million, an increase of over 19.7 per cent. The principal agency engaged in intramural medical research is the Department of National Health and Welfare, which spent $8 million on research and development studies and related scientific activities in the fields of radiation protection, air pollution, occupational health, environmental health, biochemistry, epidemiology, and health services. The Department of Veterans Affairs continued a variety of clinical studies in chronic disease problems including a psychiatric research program, that amounted to $357,000 in 1967-68. The National Research Council also conducts intramural investigations of importance to health in radiation biology and the biosciences.

Federal grants supporting the development of biomedical research and research personnel in universities and hospitals have been channelled mainly through the Medical Research Council, although significant outlays are made by other agencies in special fields such as public health, defense, and dental research. Moreover, the expansion of research plant is one of the key objectives of the Health Resources Program of the Department of National Health and Welfare.

The Medical Research Council spent $20.5 million in 1967-68, of which $7,759,000 was allocated for annual grants-in-aid, $4,991,000 for three-year term research projects, $2,638,000 for equipment grants, $3,760,000 for research scholarships and fellowships, and $1,351,000 for other research promotion. Its 1968-69 budget for these programs has been increased to $26,943,000.

Under the Public Health Research Grant, the Department of National Health and Welfare allocated $4,090,000 in 1967-68 to applied and developmental research projects, conducted by universities, hospitals, health departments, and other non-profit health organizations; in addition, it gave $424,000 for physiological research under the Fitness and Amateur Sport Grant, $152,000 for research and demonstration projects on health aspects of mental retardation, and $23,000 for smoking-and-health research. It is estimated that $10 million or 30 per cent of the Health Resources Fund expenditures in 1967-68 were used to build research facilities as an integral part of this program to expand the training of health personnel at medical and dental schools and affiliated centres.

Other substantial grants-in-aid of research were made to the universities by the Defense Research Board for studies in arctic medicine and climatic physiology, aviation medicine, radiation protection and treatment, toxicology, and other special areas. In 1967-68 this support totalled $473,000. The remaining extramural program, for dental research, which has been administered by the National Research Council's Associate Committee on Dental Research, spent $419,000 in 1967-68.

The principal voluntary agencies supporting medical research in Canada, related to their special interests, are the National Cancer Institute, Canadian Arthritis and Rheumatism Society, Multiple Sclerosis Society, and the Muscular Dystrophy Society. The Interdepartmental Committee on Medical Research provides a forum for the sharing of information and support of medical research to which the voluntary agencies are invited. The Medical Research Council now reports to Parliament through the Minister of National Health and Welfare.

Subsection 4. Radiation Protection

The Department of National Health and Welfare as the principal adviser to the Atomic Energy Control Board under the Atomic Energy Control Regulations reviews all applications for licenses to procure radioactive materials and recommends health and safety measures. In carrying out this function the Department has developed codes for the safe handling of all radioactive materials.

It has also developed a comprehensive program in order to protect the public from harmful radiation that could arise through the uncontrolled use of radioactive materials, X-ray equipment, nuclear reactors and other sources, and in order to meet the general concern about radiation from the testing of nuclear weapons and from medical X-ray procedures. Members of the Department serve on special advisory committees to the Atomic Energy Control Board who review the location, design, construction and operation of proposed nuclear reactors and charged-particle accelerators (cyclotrons) and make recommendations on their health and safety aspects.

Concerning the use of X-rays the Federal Government does not have authority to enforce health and safety measures. The Department, however, has established a committee on the development of X-ray-safety standards, who establish standards and procedures recommended for use throughout Canada. It has recommended that the sale of X-ray equipment be subjected to federal control and its installation to provincial control. Some provinces have already enacted enabling legislation concerning X-ray equipment and some require registration of operators and equipment.

The Department also serves as co-ordinator for federal departments and agencies that could deal with radiation accidents, and provides short training courses in radiation protection.

The Department provides direct protection services to workers. It supplies detection devices that workers wear on their bodies and examines the devices periodically to determine the amount of radiation to which the worker has been exposed. Where there is a hazard of ingestion or inhalation of radioactive substances, the Department analyzes breath and urine of the workers, and in case of an accident, or when an accident is suspected, it will examine the person in the "whole body counter", a device which measures radiation emanating from a living person.

It also operates laboratories for monitoring and research. Radioactive fall-out is monitored all over the country as well as water, air, and food products in the vicinity of nuclear reactors. The research is directed towards improvement of measuring radiation exposure; tracing of radioactive fall-out elements through rain to soil, through plant tissue and thence to domestic animals and through the human body; and studying the effect of radiation on tissues, blood, and cells in order to explore the relationship between radiation and disease.

Subsection 5 - Consultative and Technical Services

The extension of technical and consultative assistance to the provinces is a function of the Health Services Branch and the Health Insurance and Resources Branch of the Department of National Health and Welfare. The following specialized services supply consultation and information, advise on health care projects, co-ordinate activities and planning, and exercise leadership in promoting high standards of service: Child and Maternal Health; Dental Health; Emergency Health; Epidemiology; Health Education; Laboratory of Hygiene; Medical Rehabilitation; Mental Health; Nursing Services; Nutrition; Occupational Health; Radiation Protection; Public Health Engineering; Research Development; Health Grants; Health Resources; Hospital Insurance and Diagnostic Services; Health Facilities Design; Medical Care Insurance and Research and Statistics. In addition, the Information Services of the Department produces and distributes a variety of literature, films and radio programs to inform and educate the public on health subjects.

Subsection 6 - Special Programs

The Department of National Health and Welfare also carries out a number of specialized health services that are of national concern. Among these are the Emergency Health Services which assists provincial and municipal governments to organize emergency medical, nursing, hospital and public health services (see p. 47) the Laboratory of Hygiene including the Virus Laboratory which serves as the national reference centre for the diagnosis of bacterial and viral diseases of man; and the Radiation Protection Division that is responsible for safety measures to protect Canadians from harmful radiation (see p. 11).

The Environmental Health Centre carries out specialized advisory and research services in occupational health, aerospace medicine, and public health engineering, which deals with

health problems of interprovincial and international traffic and water resources management. The National Tuberculosis Reference Centre in Ottawa, administered by the Laboratory of Hygiene, was opened in 1968 to establish uniform standards in testing for resistance to anti-tuberculosis drugs.

Section 2 - Federal-Provincial Health Activities

The Department of National Health and Welfare serves the provinces in an advisory and co-ordinating capacity and administers grants to provincial and voluntary health agencies. Administration of federal aspects of the Health Resources Fund and the Hospital Insurance and National Health Grant programs is a major activity. Co-ordination with the provinces on health matters is facilitated by the Dominion Council of Health.

Subsection 1 - Medical Care

The Medical Care Act was passed by the Canadian Parliament in December 1966 and became operative on July 1, 1968. British Columbia and Saskatchewan entered the plan on that date and several other provinces had signified firm intention to enter by April 1, 1969. The provisions of this statute are based on principles outlined by the Prime Minister in July 1965, when he announced the intention of the Government to make available to the provinces federal financial contributions for provincially administered medical care programs.

In accordance with the terms of the Medical Care Act, the Government of Canada contributes to any participating province half the per capita cost of all insured services furnished under the plans of all participating provinces multiplied by the number of insured persons in that one province. In order to benefit from this federal contribution, a provincial plan must meet the following criteria:

(1) the plan must be operated on a non-profit basis by a public authority set up by the provincial government, subject in respect of its accounts and financial transactions to provincial audit;

(2) the plan must make available on uniform terms and conditions to all insurable residents of the province, insured services, which are defined as all medically necessary services rendered by medical practitioners, for whom the provincial law must provide reasonable compensation, so as to ensure reasonable access to insured services by insured persons;

(3) the plan must give entitlement to not less than 90 per cent of the number of eligible residents of the province during the first two years and not less than 95 per cent thereafter;

(4) for persons normally resident in Canada, the plan must not impose any minimum period of residence, although up to three months' waiting period for entitlement within a province is permissible if portability is provided for, so that persons retain coverage when temporarily absent from the province or during any required waiting period of not more than three months, for benefits in another province on change of residence.

In addition to the comprehensive physicians' services which must be provided as insured services by participating provinces, the Medical Care Act empowers the government to include any additional health services under terms and conditions which may be specified by the Governor-in-Council.

All insured services must be provided without exclusion because of age, ability to pay, or other circumstances.

The Canada Assistance Plan, described elsewhere in detail, provides for federal contributions of half the costs of health care services (as well as income maintenance) that provinces make available to persons establishing eligibility on the basis of financial need.

Subsection 2 - Health Resources Program

The Health Resources Program is concerned with manpower in the health fields necessary for the provision of comprehensive health services to Canadians. Under the program the Government of Canada provides capital grants for teaching and research establishments, undertakes studies on health manpower, and offers advice and consultation.

The capital-grant aspect of the program was inaugurated when in July 1966 Parliament passed the Health Resources Fund Act, which was established to develop resources for the training of personnel in order to reduce shortages and to meet the increase in demand that is likely to follow the introduction of medical-care insurance. The Act established a fund of 500 million dollars, available over the period 1966 to 1980. Out of this fund the Government will pay up to 50 per cent of the cost of planning, construction, purchase, renovation, and basic equipment of teaching hospitals, medical schools, training facilities for nurses and other health professionals, and research establishments; the costs of land, interest, and

residential buildings are excluded. Of the 500 million dollars, 300 million are available to the provinces in proportion to their populations; another 25 million dollars are available to the Atlantic provinces for joint projects in which all the four provinces participate; while the remaining 175 million dollars are yet to be allocated. By March 31st, 1968, the Government had approved contributions of 81 million dollars and paid out 37 million. About two-thirds of these sums were for training facilities, and one-third for research establishments.

In 1967, the Government called a Medical Manpower Conference, which approved a program of studies of various aspects of the supply, distribution, training, and use of professional and technical people in the health services. These health-manpower studies are intended to be undertaken by a team of consultants in the Department.

The Department also provides technical and professional advice and consults with officials of provincial governments and other agencies who are concerned with the development of health resources in Canada, and supports programs to increase the effectiveness of health manpower. These activities are undertaken in order that the Health Resources Fund shall be used more economically and efficiently.

Subsection 3 - National Health Grant Program

The National Health Grant program was instituted in 1948 to assist the provinces in extending and improving public health and hospital services. As provincial needs have altered, changes have been made in the amounts and conditions of individual grants. Table 1 shows the utilization of the National Health Grants and changes in their classification since inception, and the current grants, as follows: Professional Training, Hospital Construction, Mental Health, Tuberculosis Control, Public Health Research, General Public Health, Cancer Control, Medical Rehabilitation and Crippled Children, and Child and Maternal Health. During the period from 1948 to 1967, the total expenditures under this program were $717 million, representing 81 per cent of the funds allocated. In 1967-68 utilization reached 92 per cent.

The largest single grant has been in support of hospital construction. Up to March 31st, 1968, funds had been approved for the construction of buildings for 126,356 hospital beds and 15,840 basinets, 24,023 beds for nurses, and 916 beds for interns. The second largest grant, the General Public Health Grant, has assisted the provinces in extending local health services to prevent disease and control environmental health hazards. Since 1948 more than 50,000 health personnel have

TABLE 1 - AMOUNTS ALLOCATED AND AMOUNTS AND PERCENTAGES EXPENDED UNDER THE NATIONAL HEALTH GRANTS PROGRAM, BY GRANT, FOR THE PERIOD ENDED MARCH 31, 1967, AND FOR THE YEAR ENDED MARCH 31, 1968.

GRANT	May 14, 1948 - March 31, 1967			Year Ended March 31, 1968		
	Amount Allocated(1)	Amount Expended(2)	Percentage Expended(3)	Amount Allocated(1)	Amount Expended(2&4)	Percentage Expended(3)
	$	$		$	$	
Crippled Children(5)	6,207,728	4,431,677	71	-	-	-
Professional Training	19,435,373	18,994,271	98	1,991,900	2,103,504	106
Hospital Construction(6)	271,883,104	250,419,287	92	20,367,320	16,401,662	81
Venereal Disease Control(7)	5,968,336	5,146,209	86	-	-	-
Mental Health	136,845,669	116,614,247	86	8,656,650	8,391,840	97
Tuberculosis Control	70,006,429	66,027,849	94	1,923,700	2,296,428	119
Public Health Research	23,141,888	20,529,358	88	4,581,370	4,799,107	105
Health Survey(8)	645,180	540,960	84	-	-	-
General Public Health	189,596,069	139,989,207	74	17,076,597	17,675,907	104
Cancer Control	64,182,967	46,976,706	73	1,923,700	1,629,076	85
Laboratory and Radiological Services(9)	47,404,300	14,450,881	30	-	-	-
Medical Rehabilitation(10)	6,500,000	3,016,750	46	-	-	-
Medical Rehabilitation and Crippled Children(11)	19,381,795	13,543,349	70	2,885,550	1,652,784	57
Child and Maternal Health(12)	24,049,794	16,539,989	69	1,923,700	1,550,994	81
TOTAL	885,248,632	717,220,740	81	61,330,487	56,501,302	92

(1) As set out in the Orders-in-Council authorizing the General Health Grants and Hospital Construction Grants for the years cited. Provinces may vary the amounts allocated for individual General Health Grants by transfer of unexpended funds from one Grant to another.
(2) Total expenditures for each Grant for all provinces including Quebec's share that has been paid through tax rebate under the Established Programs (Interim Arrangements) Act effective 1965-1966.
(3) Preliminary figures.
(4) Because of grant transfers, expenditures may exceed 100 per cent of amounts allocated.
(5) Merged with the Medical Rehabilitation Grant, April 1, 1960.
(6) The amounts allocated exclude revotes for unclaimed allocations as from April 1, 1953.
(7) Absorbed into the General Public Health Grant, April 1, 1960.
(8) Lapsed in 1953 following the completion of provincial health surveys.
(9) Introduced in 1953 and absorbed into the General Public Health Grant, April 1, 1960.
(10) Introduced in 1953 and merged with the Crippled Children Grant, April 1, 1960.
(11) From 1960 only; see footnotes 5 and 10.
(12) Introduced in 1953.

received bursaries for special training and in 1967-68 alone more than 6,000 health workers were employed with the aid of grant funds. Other grants are designated for preventive and treatment services in specific areas such as mental health, tuberculosis, and cancer, improvement of maternity, infant, and child care, and the correction and treatment of crippling conditions.

Projects supported by the Public Health Research Grant relate to the prevention of disease, disability, or death; epidemiology; hospital administration; community-based health and medical care; operational research; environmental health, including sanitation; and the training and utilization of health manpower.

Subsection 4 - Hospital Insurance

Provincial hospital insurance programs under the Hospital Insurance and Diagnostic Services Act of 1957 have been operating in all provinces and territories since 1961; they cover 99 per cent of the population of Canada. Under the Act the Government of Canada shares with the provinces the cost of providing specified hospital services to insured patients. Specifically excluded are tuberculosis hospitals and sanatoria, hospitals or institutions for the mentally ill, as well as institutions, the purpose of which is the provision of custodial care, such as nursing homes and homes for the aged. The methods of administering and financing the program in each province and the provision of services above the stipulated minimum that is required by the Act are left to the choice of the province.

When the Act was passed in 1957 Newfoundland, Saskatchewan, Alberta, and British Columbia were already operating their own hospital insurance plans; those four provinces and Manitoba entered federal-provincial agreements on July 1, 1968, the earliest possible date under the new Act. Prince Edward Island, Nova Scotia, New Brunswick, and Ontario followed in 1959, the Territories in 1960, and Quebec in 1961.

Insured in-patient services must include accommodation, meals, necessary nursing service, diagnostic procedures, pharmaceuticals, the use of operating rooms, case rooms, anaesthetic facilities, and the use of radiotherapy and physiotherapy if available. Similar out-patient services may be included in provincial plans and authorized for contribution under the Act. All provinces include some out-patient services. The provincial plans are administered by the provincial department of health in some provinces and by a separate commission in others. To finance the insurance plans, the provinces use general revenue, sales taxes and

premiums in various combinations.* The Government of Canada contributes out of the consolidated revenue fund in respect to each province, the sum of 25 per cent of the per capita cost of in-patient services in Canada and 25 per cent of the per capita cost of in-patient services in the province, which is then multiplied by the average number of insured people in that province. Contributions for insured out-patient services with respect to each province are paid in the same proportion as the contributions to the cost for in-patients. Since January 1st, 1965, contributions to Quebec under the Hospital Insurance and Diagnostic Services Act have been replaced by arrangements under the Established Programs (Interim Arrangements) Act.

Table 2 shows the proportion the Government of Canada contributes of the cost of insured hospital services in each province. It varies according to law around 50 per cent, from 47 per cent for Ontario to 63 per cent for Prince Edward Island, so that the less the average cost per person is in a province, the greater the proportion which the province recovers from the central government.

Tables 3 to 12, unless otherwise stated, contain statistics on the hospitals that are listed in the federal-provincial hospital insurance agreements. Most of these are "budget review" hospitals, that is hospitals whose budgets have to be approved by provincial government authority. They are publicly owned general and special hospitals. "Contract" hospitals are not publicly owned; they provide care to insured patients under contract with the provincial agency. Hospitals of the Government of Canada are operated by the Departments of National Health and Welfare, Veterans Affairs, and National Defence.

Table 3 shows that 1,293 hospitals in Canada were listed in the federal-provincial agreements at the end of 1966. Table 4 shows that the total number of beds at the end of 1966 was 137,272, or 6.8 beds per thousand population. This ratio ranged from 5.7 in Prince Edward Island to 8.7 in Alberta and is still higher in the territories.

Table 5 shows patient-days in hospitals that are listed in the agreements. The total, 40.1 million, corresponds to a rate of 2,004 patient-days per thousand population for Canada. The rate ranged from 1,496 in Newfoundland to 2,320 in Saskatchewan.

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*All provinces use general revenue; Ontario, Manitoba and Saskatchewan impose premiums; Alberta levies a special tax on municipalities; and Saskatchewan, Alberta, British Columbia, and the Northwest Territories impose a daily charge at the time of service.

TABLE 2 - PERCENTAGES WHICH THE GOVERNMENT OF CANADA CONTRIBUTED OF THE COSTS OF INSURED HOSPITAL SERVICES UNDER THE HOSPITAL INSURANCE AND DIAGNOSTIC SERVICES ACT, 1965 TO 1968.

Province	1965	1966(1)	1967(1)	1968(1)
Newfoundland	55	54	57	52
Prince Edward Island	63	59	59	63
Nova Scotia	55	54	50	53
New Brunswick	52	51	50	52
Ontario	48	47	47	47
Manitoba	52	50	51	51
Saskatchewan	48	47	49	51
Alberta	49	44	45	50
British Columbia	53	51	52	52
Yukon	57	53	54	57
Northwest Territories	43	45	48	52

(1) preliminary

TABLE 3 - NUMBER OF HOSPITALS AND OTHER FACILITIES LISTED IN HOSPITAL INSURANCE AGREEMENTS, BY STATUS, CANADA AND PROVINCES, DECEMBER 31st, 1966

Province	Hospitals				Other facilities(1)			Total
	Budget review	Contract(2)	Gov't of Canada	Total(2)	Budget review	Contract	Total	
Newfoundland	46	1	1	48	-	1	1	49
Prince Edward Island	9	-	-	9	-	1	1	10
Nova Scotia	47	-	1	48	-	2	2	50
New Brunswick	39	-	1	40	-	1	1	41
Quebec	170	84	11	265	4	2	6	271
Ontario	220	84	12	316	-	4	4	320
Manitoba	81	5	16	102	1	1	2	104
Saskatchewan	151	5	3	159	5	3	8	167
Alberta	142	2	8	152	5	15	20	172
British Columbia	101	13	6	120	-	1	1	121
Yukon	2	-	3	5	-	1	1	6
Northwest Territories	2	7	20	29	-	1	1	30
Canada	1,010	201	82	1,293	15	33	48	1,341

(1) Includes clinics, medical centres, physical restoration centres, laboratories, radiological facilities, and Red Cross blood depots.
(2) Excludes the three listed hospitals in the U.S.A.

TABLE 4 - BEDS (EXCLUDING BASSINETS) IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, NUMBER AND RATIO PER 1,000 POPULATION, CANADA AND PROVINCES, DECEMBER 31st, 1966

Province	Hospitals	Beds	
		Number	Ratio per 1,000 population
Newfoundland	48	2,978	6.0
Prince Edward Island	9	626	5.7
Nova Scotia	48	4,838	6.4
New Brunswick	40	4,034	6.5
Quebec	265	36,701	6.3
Ontario	316	47,290	6.7
Manitoba	102	7,003	7.3
Saskatchewan	159	7,822	8.2
Alberta	152	12,894	8.7
British Columbia	120	12,442	6.5
Yukon	5	160	10.7
Northwest Territories	29	484	16.7
Canada(1)	1,293	137,272	6.8

(1) The three listed hospitals in the U.S.A. are excluded.

TABLE 5 - TOTAL PATIENT-DAYS AND INSURED PATIENT-DAYS IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, NUMBER AND RATE PER 1,000 POPULATION, CANADA AND PROVINCES, 1966

Province	Hospitals reporting	Total patient-days		Patient-days paid for by the insurance plan of the reporting province	
		Number	Rate(1)	Number	Rate(2)
Newfoundland	48	737,982	1,496	681,111	1,384
Prince Edward Island	9	183,844	1,694	176,291	1,649
Nova Scotia	48	1,355,136	1,792	1,213,376	1,645
New Brunswick	40	1,199,260	1,944	1,091,314	1,794
Quebec	267	10,763,554	1,862	10,113,385	1,754
Ontario	311	14,445,301	2,075	13,060,038	1,920
Manitoba	101	1,975,573	2,051	1,782,796	1,901
Saskatchewan	158	2,216,777	2,320	2,124,079	2,247
Alberta	151	3,390,577	2,317	3,154,024	2,170
British Columbia	120	3,743,778	1,998	3,309,140	1,778
Yukon	5	25,834	1,796	21,642	1,542
Northwest Territories	27	63,955	2,225	37,232	1,318
Canada	1,285	40,101,571	2,004	36,764,428	1,861

(1) Per 1,000 population (Census of Canada)
(2) Per 1,000 persons insured under provincial plans.

Table 6 shows average length of hospital stay and occupancy ratios for budget review hospitals only. Average length of stay of patients who were discharged from or who died in general hospitals during 1966, except in the Territories, ranged from 8.8 days in Alberta to 11.0 days in Ontario; the average for Canada was 10.1 days. Length of stay in chronic hospitals is much longer and varies greatly from province to province. In the reporting convalescent hospitals, the average length of stay was 42.5 days.

The occupancy ratio in general hospitals was 79.9 per cent in 1966; in chronic hospitals, 93.3 per cent; and in convalescent hospitals, 86.9 per cent. Since occupancy varies with the size of hospital, variations in the occupancy ratio among provinces can be partially attributed to this factor. Thus, Ontario and British columbia, with many large hospitals, show the highest occupancy in general hospitals, and the territories, the lowest.

Table 7 shows 3.2 million separations (discharges and deaths) from all reporting hospitals that were listed in insurance agreements. This corresponds to a rate of 159 per thousand population. Among provinces the rates vary from 133 (Newfoundland) to 222 (Saskatchewan); the rate for the Northwest Territories, 245 per thousand, was the highest.

Table 8 shows 241,644 full-time hospital employees at the end of 1966, which is 10,257 or 4.4 per cent more than the year before, while the number of part-time employees increased by 4,662 to 33,254.

Tables 9 and 10 deal with revenue fund expenditures of budget review hospitals only. These exclude capital costs, but include expenditures for services that are not covered by hospital insurance plans. The expenditures increased by 15 per cent over the preceding year to $1,276 million, of which salaries accounted for two-thirds.

Expenditures per patient-day ranged from $26.61 in Prince Edward Island to $44.00 in Quebec, except for the Yukon where the cost per patient-day was $52.87. Regional differences reflect not only differences in the cost of labour and material, but also the proportion of care of geriatric and convalescent patients, which is less costly than care for acute illness; provinces vary in the proportion of this care that they provide in budget review hospitals. The average for Canada was $36.18 per patient-day in 1966, 13 per cent higher than in 1965.

TABLE 6 - AVERAGE LENGTH OF STAY(1) AND OCCUPANCY(2) FOR BUDGET REVIEW GENERAL, CHRONIC, AND CONVALESCENT HOSPITALS, CANADA AND PROVINCES, 1966

Province	General hospitals			Chronic hospitals			Convalescent hospitals		
	Reporting hospitals	Average length of stay	Occupancy	Reporting hospitals	Average length of stay	Occupancy	Reporting hospitals	Average length of stay	Occupancy
	Number	Days	Per cent	Number	Days	Per cent	Number	Days	Per cent
Newfoundland	43	10.7	76.5	-	-	-	-	-	-
Prince Edward Island	8	9.9	81.2	-	-	-	-	-	-
Nova Scotia	44	10.6	76.8	-	-	-	1	28.5	95.0
New Brunswick	36	10.2	81.9	1	55.5	96.3	-	-	-
Quebec	128	10.2	79.2	26	228.9	92.6	4	53.2	85.1
Ontario	194	11.0	82.6	19	270.5	95.6	6	37.3	88.0
Manitoba	77	9.1	79.3	4	138.0	91.8	-	-	-
Saskatchewan	148	9.4	76.8	4	292.5	94.6	-	-	-
Alberta	113	8.8	72.7	25	181.6	88.9	-	-	-
British Columbia	89	9.3	82.7	5	178.2	98.4	-	-	-
Yukon	2	6.0	34.8	-	-	-	-	-	-
Northwest Territories	2	6.8	66.3	-	-	-	-	-	-
Canada	884	10.1	79.9	84	221.4	93.3	11	42.5	86.9

(1) Average hospital stay since admission of patients who left hospital by discharge, death, or transfer during 1966, excluding the newborn.

(2) Ratio of the average number of patients to the number of available beds.

TABLE 7 - SEPARATIONS (EXCLUDING NEWBORN) FROM HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, NUMBER AND RATE PER 1,000 POPULATION, CANADA AND PROVINCES, 1965

Province	Reporting hospitals	Separations	
		Number	Rate per 1,000 population
Newfoundland	48	65,533	133
Prince Edward Island	9	18,156	167
Nova Scotia	48	117,943	156
New Brunswick	40	107,319	174
Quebec	265	792,489	137
Ontario	316	1,064,988	153
Manitoba	102	175,030	182
Saskatchewan	159	211,641	222
Alberta	152	292,460	200
British Columbia	120	329,058	176
Yukon	5	2,961	206
Northwest Territories	29	7,053	245
Canada	1,293	3,184,631	159

TABLE 8 - PERSONNEL IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS(1) CANADA AND PROVINCES, DECEMBER 31st, 1965

Province	Number of hospitals	Number of employees	
		Full-time	Part-time
Newfoundland	48	5,322	233
Prince Edward Island	9	1,071	82
Nova Scotia	48	8,687	1,046
New Brunswick	40	7,651	608
Quebec	264	75,642	7,749
Ontario	311	82,557	15,344
Manitoba	101	11,798	2,269
Saskatchewan	157	11,511	1,404
Alberta	151	18,645	2,089
British Columbia	120	18,240	2,353
Yukon	5	158	9
Northwest Territories	27	362	69
Canada	1,281	241,644	33,254

(1) Includes 142 full-time and 3 part-time technicians in public-health laboratories.

TABLE 9 - REVENUE FUND EXPENDITURES OF BUDGET REVIEW HOSPITALS CANADA AND PROVINCES, 1966

Province	Number of reporting hospitals	Total expenditures	Expenditures per patient-day(1)	Expenditures per capita
		$'000's	$	$
Newfoundland	46	23,222	32.10	47.07
Prince Edward Island	9	4,892	26.61	45.08
Nova Scotia	47	41,414	34.01	54.78
New Brunswick	39	35,729	32.31	57.93
Quebec	170	401,347	44.00	69.43
Ontario	220	457,043	35.63	65.66
Manitoba	82	55,787	31.34	57.93
Saskatchewan	144	60,190	30.60	63.00
Alberta	142	94,244	30.04	64.41
British Columbia	101	101,561	31.80	54.20
Yukon	2	175	52.87	12.14
Northwest Territories	2	487	33.84	16.94
Canada	1,004	1,276,090	36.18	63.76

(1) Excludes the newborn.

TABLE 10 - REVENUE FUND EXPENDITURES OF BUDGET REVIEW HOSPITALS BY TYPE OF ACCOUNT, CANADA, 1966

Item	Total expenditures	Expenditures per patient-day(1)	Expenditures per capita(2)	Percentage distribution
	$'000's	$	$	
Salaries and wages	838,299	23.77	41.88	65.7
Medical and surgical supplies	38,774	1.10	1.94	3.0
Drugs	46,581	1.32	2.33	3.7
Raw food	59,645	1.69	2.98	4.7
Other expenses(3)	292,790	8.30	14.63	22.9
Total	1,276,090	36.18	63.76	100.0

(1) Excludes the newborn.

(2) According to the Census of Canada.

(3) Includes electricity, maintenance, services, repairs, interest, depreciation, rent, and other supplies.

The per capita amount of the expenditures of budget review hospitals in 1966 ranged from $69.43 in Quebec to $45.08 in Prince Edward Island, and was far lower in the Territories. The national average was $63.76, exceeded only in Quebec, Ontario ($65.66), and Alberta ($64.41). Although the budget review hospitals did provide 88 per cent of all insured patient-days in Canada comparisons between provinces should be made with care, because that percentage varies considerably.

Table 10 shows that the largest cost component was salaries, 65.7 per cent of the total. This item has been increasing more than the other components. It reflects the increased staff-patient ratio and increases in salaries as well as the greater use of special skills that modern hospital care requires.

Tables 11 and 12 are based on patients who left hospital in 1965. Table 11 shows how often people are in hospital (separations per 1,000 population), how much hospital care people use (days in hospital since admission per 1,000 population), and the average length of hospital stay, for different age-groups and by sex. Table 12 shows the same statistics as Table 11 for 17 diagnostic categories.

Subsection 5 - Dominion Council of Health

The Dominion Council of Health, established in 1919, advises the Minister of National Health and Welfare on matters relating to the promotion and preservation of the health of the people of Canada. It meets twice a year and consists of the Deputy Minister of National Health, who acts as chairman, and of the chief executive officer of the department of health of each province, as well as up to five persons whom the Governor-in-Council appoints for a period of three years. Traditionally these are chosen from the field of agriculture, medical science, organized labour, and from women's organizations.

The Council is supported by special advisory committees who deal with specific aspects of public health and who are appointed by Order in Council.

TABLE 11 - SEPARATIONS AND DAYS OF CARE SINCE ADMISSION: RATES PER 1,000 POPULATION AND AVERAGE LENGTH OF STAY FOR PATIENTS(1) INSURED BY PROVINCIAL PLANS, BY SEX AND AGE, CANADA, 1966

Item	0-4 years	5-14 years	15-24 years	25-44 years	45-59 years	60-64 years	65-74 years	75 years and over	All ages
Separations per 1,000 population(2)									
Male	193	88	76	88	150	220	287	416	129
Female	150	78	228	246	171	190	239	340	186
Both sexes	172	83	151	167	161	205	262	374	158
Days in hospital since admission per 1,000 population(2)									
Male	1,581	548	619	938	2,173	3,910	6,127	11,871	1,668
Female	1,264	452	1,448	2,007	2,386	3,554	5,673	13,010	2,145
Both sexes	1,427	501	1,032	1,470	2,279	3,731	5,888	12,494	1,905
Average length of stay (days)									
Male	8.2	6.2	8.2	10.6	14.5	17.8	21.4	28.6	12.9
Female	8.4	5.8	6.4	8.2	13.9	18.7	23.7	38.2	11.5
Both sexes	8.3	6.0	6.8	8.8	14.2	18.2	22.5	33.4	12.1

(1) Excludes the newborn.
(2) Census of Canada, 1966.

Source: Provincial Plans

TABLE 12 - DIAGNOSES OF PATIENTS(1) INSURED BY PROVINCIAL PLANS(2) CANADA, 1966

Section of the International Classification of Diseases	Separations		Patient-days since admission		Average length of stay (days)	Percentage distribution	
	Number	Rate per 1,000 population	Number	Rate per 1,000 population		Separations	Patient-days
I. Infective and parasitic diseases	43,120	2.2	574,352	28.7	13.3	1.4	1.5
II. Neoplasms	181,252	9.1	3,381,720	169.0	18.7	5.8	9.0
III. Allergic, endocrine system, metabolic, and nutritional diseases	93,124	4.7	1,505,242	75.2	16.2	3.0	4.0
IV. Diseases of the blood and blood-forming organs	18,414	0.9	282,030	14.1	15.3	0.6	0.7
V. Mental, psychoneurotic, and personality disorders	91,091	4.6	1,547,724	77.3	17.0	2.9	4.1
VI. Diseases of the nervous system and sense organs	162,391	8.1	4,348,285	217.3	26.8	5.2	11.6
VII. Diseases of the circulatory system	261,282	13.1	5,679,660	283.8	21.7	8.3	15.1
VIII. Diseases of the respiratory system	502,571	25.1	3,365,452	168.1	6.7	16.0	8.9
IX. Diseases of the digestive system	424,531	21.2	4,375,844	218.6	10.3	13.6	11.6
X. Diseases of the genito-urinary system	266,192	13.3	2,495,040	124.7	9.4	8.5	6.6
XI. Deliveries and complications of pregnancy, childbirth, and the puerperium	517,113	25.8	2,979,531	148.9	5.8	16.5	7.9
XII. Diseases of the skin and cellular tissue	58,742	2.9	584,759	29.2	10.0	1.9	1.6
XIII. Diseases of the bones and organs of movement	112,735	5.6	2,108,900	105.4	18.7	3.6	5.6
XIV. Congenital malformations	33,020	1.6	497,587	24.9	15.1	1.1	1.3
XV. Certain diseases of early infancy	9,919	0.5	136,257	6.8	13.7	0.3	0.4
XVI. Symptoms, senility, and ill-defined conditions	80,118	4.0	596,392	29.8	7.4	2.6	1.6
XVII. Accidents, poisonings, and violence	277,200	13.8	3,182,487	159.0	11.5	8.8	8.5
All diagnoses	3,132,815	156.5	37,641,262	1,880.7	12.0	100.0	100.0

(1) Excludes the newborn and certain special cases, such as examinations, inoculations, fittings, etc. (Y00-Y18, Y40-Y88 of the International Classification of Diseases).

(2) Some provinces included cases that were not paid for under their plans. Others excluded insured cases where the patients were treated outside the province. Saskatchewan excluded data from four geriatric hospitals.

Section 3 - Provincial and Local Health Services

Provincial governments are mainly responsible for the various health measures to prevent disease and improve the health standards of the community. These comprise preventive health services, hospital services, mental health services, treatment services for tuberculosis and other diseases, and special treatment services and care of the chronically ill and disabled. They are usually administered by the provincial health department or other official agency in co-operation with the hospitals and other voluntary health organizations, the health professions and the teaching and research institutions.

Although the pattern of services is similar, provincial health organization, financing, and administration vary to some degree. Most health functions are exercised by the provincial health departments, but in some provinces, certain programs such as hospital insurance, medical care insurance, tuberculosis control, cancer control, or alcoholism programs are administered by separate public agencies directly accountable to the minister of health. Voluntary organizations also provide specialized health services, often with some support from tax funds in the form of payment for services or support grants.

In general, the provincial health departments carry out overall planning and direction of public health programs, administer certain specialized health programs, and assist through technical and financial aid the regional or county health units and city health departments that have been delegated responsibility for the basic public health services. In most provinces, the health unit systems, which serve mainly rural areas, are operated either by the province or jointly by the province and the local authority, with the local authority having jurisdiction over county, municipality or larger area, while city health departments are administered by municipal or metropolitan boards of health. Several provincial health departments also directly administer health services to northern unorganized territories. The nucleus staff of a local health unit or department usually is composed of a full-time medical officer of health, a number of public health nurses and a public health inspector.

Local programs to safeguard community health are concerned with environmental sanitation to ensure safe water, milk, and other foods, prevention and control of infectious diseases through use of vaccines and prophylactics, the improvement of maternal and child health and dental health, registration of vital statistics, and health education and

counselling. In addition, the larger city health departments have developed specialized services in such areas as mental health, home care, and rehabilitation of the chronically ill and the handicapped. More recently, health units and departments in most provinces have started health screening for chronic conditions and family planning clinics. The city health departments also participate in some degree with the provincial authorities in accident prevention and in measures to control air, water, and soil pollution.

Provincial health departments support the local programs by health grants and the provision of technical consultant services. Most of the mental and tuberculosis hospitals and clinics are provincially operated, as are treatment services for the venereal diseases, cancer, alcoholism, and other specific diseases, and the laboratories that aid both the public health agencies and practising physicians in diagnostic and control procedures. The provincial agencies are primarily responsible for the collection and analysis of vital statistics and the study of the epidemiological and related social and economic conditions that affect health. They also give leadership in such fields as occupational health, nutrition, health education, and pollution problems, in collaboration with national health agencies. In order to maintain and improve the health services, the provincial health departments recruit and train professional and technical personnel for the health fields and support public health research.

Subsection 1 - Public Health Services

Environmental health. - The control of factors in the environment that are harmful to health is an expanding area of public health. Much of the work in community sanitation involves inspection duties to maintain safe milk, water, and food supplies and sanitary conditions in sewerage and waste disposal systems and in public areas such as camp sites and swimming pools. Air pollution, water pollution, radiation exposure, and the use of pesticides have become major problems, necessitating the co-operative efforts of governments and other agencies in research and in planning effective control measures. Special water authorities in Ontario and Quebec have responsibility for all aspects of public water supply, sewerage systems, and stream pollution, and in six other provinces special water agencies exercise similar functions jointly with the health departments. Six provincial health departments have implemented measures to control air pollution.

Occupational health. - Services designed to prevent accidents and occupational diseases and to maintain the health of employees are the common concern of provincial health departments, labour departments, workmen's compensation boards, and industrial management. Provincial agencies regulate working conditions and offer consultant and educational services to industry. All provinces have legislation (factory acts, shop acts, mines acts, workmen's compensation acts) setting standards for health safety and accident prevention on the job. Most provinces maintain environmental health laboratories that study industrial health problems such as the effects of noise and air conditions on workers.

Communicable disease control. - The larger provincial health departments have separate divisions of communicable disease control headed by full-time epidemiologists whereas in the smaller provinces this function is combined with one or more community health services. Local health authorities organize immunization clinics against diphtheria, tetanus, poliomyelitis, whooping cough, smallpox, and measles. They also engage in case-finding and diagnostic services in co-operation with public health laboratories and private physicians. Special services for tuberculosis and venereal disease are noted on page 37 and 38.

Health education. - A basic concern of provincial health authorities is to stimulate public interest in important health needs, and most provincial health departments have a division or unit of health education under a full-time professional "health educator". The division provides education materials to other divisions of the health department, to local health authorities, and to voluntary associations. Many educational activities are directed to reducing habits harmful to health, such as cigarette smoking and the excessive use of alcohol and other drugs.

Public Health laboratories. - All provinces maintain a central public health laboratory and most have branch laboratories to assist local health agencies and the medical profession in the protection of community health and the control of infectious diseases. Public health bacteriology (testing of milk, water, and food), diagnostic bacteriology, and pathology are the principal functions of the laboratory service, with medical testing for physicians and hospitals steadily increasing in volume. Efforts to co-ordinate public health and hospital laboratory services and measures to bring laboratory facilities to rural areas are among the recent developments.

Maternal and child health. - Public health nurses employed by the local health services carry out preventive health services to mothers, newborns and children through clinics, home and hospital visits and school health services. All provincial health departments have established maternal and child health consultant services that co-operate with the public health nursing services. The maternal and child health divisions established in five provinces also undertake studies in maternal and child care, including hospital care, and assist in the training of nursing personnel.

Nutrition. - Provincial health departments and some city health departments employ consultants in nutrition to extend technical guidance and education to health and welfare agencies, nursing homes and other care institutions and hospitals. They also provide diet counselling to selected patient groups and conduct nutritional surveys and other research.

Dental health. - Provincial dental public health programs have been largely preventive, but increasing emphasis is now being given to dental care. The dental health divisions support the dental clinics conducted by the local health services that are generally restricted to pre-school and younger school age groups. A number of provinces also send dental teams to remote areas and subsidize resident dentists to practice in areas lacking such services, while the four western provinces have dental care schemes of varying coverage for welfare recipients. Other activities of the public dental health programs are directed to the training of dentists and dental hygienists, the conduct of dental surveys and the extension of water fluoridation.

Subsection 2. - Mental Health Services

Mental health services in Canada are organized as part of provincial health services. Each province employs a director of mental health services, usually a psychiatrist, and one or more consultants in psychiatric nursing, clinical psychology, social work, occupational therapy or special education and also one or more psychiatrists specializing in paediatrics, geriatrics, mental retardation, alcoholism and drug addiction, or other related fields. As public health officers, the mental health directors are responsible for the development of programs aimed at prevention of mental disease and for the general promotion of mental health, on their own and in co-operation with welfare, education, manpower, labour, and justice departments. As psychiatrists they are responsible for development and supervision of the various health facilities for the treatment of people who suffer from mental or emotional disorders including disorders of character and behaviour, the

mentally retarded, people with damage to the nervous system, alcoholics and drug addicts.

Mental health services differ in detail and stage of development from province to province; all are being extended and improved to take advantage of the best methods of treatment and prevention. The traditional pattern of long-term care of the mentally ill and retarded in large isolated mental hospitals and in hospitals for mentally defectives is giving way to new patterns of care that are designed to cure the afflicted or, failing that, to provide for them living and working environments that will enable them to lead reasonably normal lives.

The mental hospitals are now placing less emphasis on custodial care and are more and more stressing intensive psychiatric treatment. They now admit voluntary patients who receive much the same care and treatment as they would receive as patients in a general hospital. Many of those who would not profit from intensive psychiatric treatment -- the severely retarded and people with severe mental deterioration -- are being supported under welfare auspices in sheltered workshops, nursing homes, or foster homes, and continue to receive medical care. In addition to the mental hospitals some special "psychiatric" hospitals have been providing intensive psychiatric care over short periods of hospital stay. Psychiatric units and out-patient psychiatric departments are being established in large general hospitals. Local authorities and, in some cases, provincial health departments are establishing mental health clinics in most large cities, while travelling clinics are visiting suburban and rural areas. In order that patients who require care in hospital may remain at their daily occupation and continue to live in their homes, psychiatric hospitals and mental-health clinics are establishing more and more day-care and night-care facilities. In these, some patients receive part-time hospital care and therapy during the day and go home at night; others go to work during the day and return to hospital in the evening for treatment.

Extending mental health services into the community aims at preventing severe mental and emotional breakdowns and at reducing the number of people who require treatment in institutions. Through early diagnosis and treatment in a mental-health clinic or out-patient department of the local hospital in the patient's neighbourhood rather than at a distant institution, he may continue to live at home and pursue his normal occupation while receiving psychiatric treatment.

Special centres are also being established for the study and treatment of alcoholism and drug addiction, criminal psychopathy, psychiatric disorders in children, brain injuries, and other neurological disorders. Along with these developments

in the mental health services the provinces are amending the pertinent legislation in order to guarantee the rights of the mentally ill, the emotionally disturbed, and the intellectually retarded.

The continuing efforts by provincial health departments to provide more and better mental health services reflect growing enlightenment about mental health on the part of the medical profession, the general public, and government agencies. Improvement in the care of psychiatric patients has been fostered by activities of voluntary organizations such as the Canadian Mental Health Association and the Canadian Association for the Mentally Retarded, by the professional advice of the Canadian Medical Association and the Canadian Psychiatric Association; by the national health grants and the national welfare grants for new services, professional training, and scientific research; and through the information programs of the Mental Health Division of the Department of National Health and Welfare. Much improvement is still necessary in order to provide adequate mental health services to all people in Canada. The main difficulties in reaching this goal are lack of funds and lack of trained personnel. Ignorance and indifference concerning mental and emotional disorders and the rejection of the mentally ill by society seem to be diminishing.

Subsection 3 - Services for Specific Diseases or Disabilities

Tuberculosis. - By 1967, the number of new active cases of tuberculosis in Canada rose slightly to 4,601 or 23 per 100,000 population, while deaths dropped to 658, or a record low rate of 3.2. Provincial health departments, assisted by voluntary agencies, conduct major antituberculosis programs that are based on intensive case-finding through community tuberculin testing and X-ray surveys, surveys of high-risk groups, hospital admission X-rays, and follow-up of arrested cases. BCG vaccine is used in most provinces to protect certain high-risk groups, but only Quebec and Newfoundland routinely immunize children. Treatment is free in each province, including hospital care, drugs and rehabilitation. The success of chemotherapy has generally shortened the hospital stay of tuberculosis patients and facilitated outpatient or domiciliary care.

Cancer. - Deaths from cancer in 1966 accounted for 17.6 per cent of all deaths in Canada, and the standardized cancer death rate increased to 132.0 (151.2 for males and 112.2 for females). Special provincial agencies for cancer control, usually in the health department or a separate cancer institute, carry out cancer detection and treatment, public education,

professional training, and research in co-operation with local public health services, physicians and the voluntary cancer societies. Although the provisions are not uniform, all cancer programs provide a range of free diagnostic and treatment services, to both out-patients and in-patients, that is financed by the hospital insurance programs or the federal-provincial cancer control grants. Hospital insurance benefits for cancer patients include diagnostic radiology, laboratory tests, and radiology. The cancer control programs in Alberta, Saskatchewan and New Brunswick also pay for medical and surgical services; elsewhere, some of these costs are covered under the voluntary and public medical care insurance schemes.

Venereal disease. - Because of under-reporting, public health authorities consider the real incidence of syphilis and gonorrhea to be much higher than the official rates. All health departments administer compulsory, free diagnostic and treatment services either at public clinics or, in areas lacking clinics, they pay private physicians to provide free treatment to indigents. In addition, each province supplies free drugs to physicians for treating private cases. The local health services carry out case-finding and follow-up, and assist in treatment and health education measures.

Alcoholism. - All provinces have instituted programs that are administered by the health departments or by other official agencies for the prevention and control of alcoholism. Although their scope varies, all alcoholism programs engage in public and professional education and conduct studies regarding the nature of alcoholism and related problems. Seven provincial alcoholism programs extend treatment services, mainly for out-patients, but most have established other types of treatment facilities such as in-patient centres, hostels, and special farms or prison centres for chronic offenders. Several provincial alcoholism agencies (Ontario, Quebec) have broadened their programs to include other addictions, while British Columbia supports a narcotic addiction foundation. Because addictions are widely prevalent, the hospitals, mental health services and other public and voluntary health and social agencies are also involved in their diagnosis and treatment.

Other diseases or disabilities. - Many services for persons with chronic disabilities, such as heart disease, arthritis, diabetes, visual and auditory impairments and paraplegia have been initiated by voluntary agencies assisted by federal and provincial funds. Today, treatment for specific conditions is available at hospital out-patient clinics and in-patient or day centres, at separate clinics and rehabilitation centres and under home care programs (see page 46).

Subsection 4 - Public Medical Care Programs

Provincial medical care plans. - Traditionally, patients have paid directly for personal health care services. For the services of physicians, especially, prepaid insurance has been replacing direct payment. At the end of 1966 about 12.0 million Canadians or 60 per cent of the population had some private voluntary insurance protection against the cost of physicians' services. When plans of all types, private and public, are considered together, the total with some form of protection was about 16.4 million persons or 82 per cent of the population.

Government financing of personal health care has been increasing in two directions concurrently.

First, for the indigent, most provincial governments have assured payments to physicians and several, as well, to dentists, pharmacists for prescribed drugs, optometrists, and others. Such programs have operated in several provinces for many years and the remaining provinces have recently made similar provisions. Under the Canada Assistance Plan, the cost of the services can be shared by the Government of Canada.

Secondly, for the general population, some provincial governments have introduced programs intended to ensure, if necessary by using tax revenue, that all residents can have physicians' services insurance. In Saskatchewan, coverage is compulsory and no other agency is permitted to compete in the service area covered by the public plan. In British Columbia since 1965 and in Ontario since 1966,public agencies administer optional programs available to individual applicants. In Alberta in 1963 the government established minimum benefits and maximum premiums for existing voluntary insurance plans. In 1967 this arrangement was superseded by a plan similar to those in British Columbia and Ontario.

The British Columbia and Alberta schemes cover a comprehensive range of physicians' services and also make provision for other health care benefits to be included as part of the basic contract or as options at a somewhat higher premium cost.

As of mid-1968 the publicly-administered plans in Alberta and Ontario continued to emphasize coverage by individual contracts. Private voluntary agencies were expected to offer coverage through group contracts.

In Newfoundland, the population in the Cottage Hospital Districts (i.e., isolated outlying areas) may enrol in a medical service scheme. (Additionally, all children under 16 years of age throughout the province are covered under the Children's Health Service, at no direct charge to their families, for physicians' services in hospital.)

All these plans except the Children's Health Service use premiums. To ensure that the premium burden upon individuals is not too heavy, Saskatchewan and Newfoundland cover about three-quarters of the total cost from general tax revenues. In Ontario, Alberta, and British Columbia premiums of the needy, as defined by a simple test of income adequacy, are subsidized from general tax revenues. British Columbia had also used a special taxation-supported fund to help stabilize premium levels.

When Saskatchewan entered the national medical care plan on July 1, 1968, the only change of importance was the broadening of the benefits to include eye refractions by physicians and optometrists. The entry of British Columbia on the same date involved substantial changes in the organization but little change in range of benefits or population coverage. The British Columbia Medical Services Commission became the single "public authority" and a number of nonprofit voluntary plans were especially approved as enrolment and claims-paying agencies for it.

Saskatchewan. - Only Saskatchewan has a universal-coverage medical care program. This program, which was introduced in July 1962, requires enrolment of the entire eligible population. The premiums are compulsory. The premium for a family is $24 per year; for a single person, $12. These premiums cover approximately 25 per cent of the costs of the program.

Among the medical services covered are home, office and hospital visits, surgery, obstetrics, psychiatric care outside mental hospitals, anaesthesia, laboratory and radiological services, preventive medicine, and certain services provided by dentists. There are no waiting periods for benefits and no exclusions for reasons of age or pre-existing health conditions.

Physicians may elect to receive payment in four ways. First, the physician may receive payment directly from the public administering authority of 85 per cent of the tariffs in the current schedule of fees of the organized profession after deducting the utilization fee, and accept this payment as payment in full. Secondly, patients and physicians may enrol voluntarily with an "approved health agency" that serves as intermediary, with respect to payment, between the public

authority and the physicians; here also, the physician receives 85 per cent of the net tariff as payment in full. Thirdly, a physician may elect to submit his bill directly to the patient who pays him and seeks reimbursement for 85 per cent of the net approved amount from the public authority; the physician may bill the patient directly for amounts over and above what the public authority has paid. Fourthly, patient and physician may, if they agree, settle their accounts privately without involving any public authority or approved health agency.

Originally, payment to the physicians under the plan was 85 per cent of the tariffs as published. Late in 1967 the percentage paid under the first, second, and third of the foregoing payment methods was increased to 95 for office, home, and hospital visits. In April 1968 utilization fees of $1.50 for each office and out-patient service, and $2.00 for each home call, payable by the patient to the physician, were introduced. The fee schedule of the medical profession was revised upward in August 1968. At the same time payment reverted to 85 per cent, but now was calculated from the net amount of the physician's claim after the utilization fee had been deducted.

The following statistics for the year 1967 relate to operations of the Medical Care Insurance Plan and do not represent the total public involvement in medical care in Saskatchewan. Payments for medical services are also made by such other public agencies as the Hospital Services Plan, the Cancer Commission, the Antituberculosis League, the Workmen's Compensation Board, the Swift Current Health Region Board (a separate administering agency for insured services, covering about 55,000 insured residents in the Swift Current Region), and other provincial and federal agencies paying for services provided to certain groups in the population excluded from Medical Care Insurance coverage.

A total of about 621,000 residents received benefits of $23,384,271 during the year. Of this amount $14,632,606 was paid through approved health agencies, $7,410,714 paid directly to physicians, and $1,302,737 directly to patients.

Payments for insured services in 1967 were 5.3 per cent greater than in 1966. When adjustments are made to achieve year-to-year comparability the increase was 4.8 per cent, and 3.7 per cent on a per capita basis.

The 621,000 individual beneficiaries comprised 71 per cent of the covered population. Of families covered, 84 per cent received one or more services. For the families receiving benefits the average payment was $80.06.

About 61 per cent of families received benefits of $50 or less; 17 per cent, $50 to $100; and about 14 per cent, $100 to $200. Payment on behalf of 7 per cent of families ranged from $200 to $500, and, for less than one per cent, exceeded $500.

Of the 767 Saskatchewan physicians who received at least $4,000 in payments from the Commission, 513 were general practitioners and 254 specialists.

Of the 4,900,000 individual services for which payment was made, 21.9 per cent were provided by specialists and 78.1 per cent by general practitioners. Payments to specialists amounted to 39.1 per cent of the total and payments to general practitioners, to 60.9 per cent. The overall average payment per service was $4.69 for male patients and $4.84 for female patients.

Age groups having the highest incidence of service were infants under 1 year and persons over 65. Children 5 - 14 received fewer services per capita than any other tabulated age group.

Thirty-nine per cent of all services were initial or repeat office visits. Another 22 per cent were hospital visits and an additional 6 per cent home and emergency calls. Altogether, home, office, and hospital visits represented 67 per cent of all services and 46 per cent of insurance payments. Diagnostic and laboratory tests accounted for 22 per cent of all services and 13 per cent of payments.

General practitioners made 85 per cent of home, office, and hospital calls and specialists 15 per cent. General practitioners provided 64 per cent of surgical services, obstetrical services, and anaesthetist and surgical assistance services, and specialists the remaining 36 per cent. Payments, however, for items in this particular class were divided 47 per cent to general practitioners and 53 per cent to specialists.

Alberta. - The Alberta Medical Plan introduced in October 1963 provided for public regulation of approved voluntary plans with regard to minimum benefits and maximum premiums and was primarily designed to help residents having poor health or low income to purchase voluntary medical care insurance from approved non-profit and commercial agencies. It was required that the benefits provided be comprehensive and that there could be no exclusions because of age, pre-existing health conditions, or a previous record of high utilization.

The plan was financed from personal premiums alone. The government contributed, as a subsidy, 80 per cent of the premium for persons with no taxable income, 50 per cent for

persons with annual taxable incomes from $1 to $500, and 25 per cent for persons with annual taxable incomes from $501 to $1,000.

On July 1st, 1966, this plan was supplemented by an extended health-benefit plan which, for an additional premium, offered other benefits including prescribed drugs, optometry, physiotherapy, ambulance service, osteopathy, chiropractic, podiatry, naturopathy, and certain medical supplies and appliances. A deductible amount, co-insurance charges, and limited liability applied to some of these benefits.

On July 1st, 1967, these plans were superseded by the Alberta Health Plan, operated by the Department of Health for all residents voluntarily seeking individual or family enrolment. The new plan is divided into two parts, Basic Health Services and Optional Health Services; the latter is further subdivided into Options A, B, and C. Any subscriber to the Basic Plan is eligible to contract for additional benefits, by paying additional premiums, under any one or more of the Options.

The Basic Plan covers all services of physicians, including annual health examinations, with payment of 100 per cent of the tariff; special dental surgery; limited optometric services; and podiatric and osteopathic services up to $100 annually. Option A offers as additional benefits certain services that are not already insured under the provincial hospital plan, including the daily co-insurance charge in a standard ward (limited to 180 days per year if the patient is in a chronic hospital), differential charge for a semi-private room, certain hospital out-patient charges, and ambulance benefits up to $100 per year. Option B covers prosthetic appliances and up to 80 per cent of the cost of prescribed drugs. For prescribed drugs, the subscriber pays 20 per cent or $1 per prescription, whichever is greater. Purchase and repair of artificial limbs, eyes, and braces, prescribed by a physician, are also covered up to $300 per year. Option C offers chiropractic and naturopathic services up to $100 per year.

Premium rates for the Basic Plan are $76 per year for single persons, $152 for families of two persons, and $200 for families of three or more. Options A and B cost an additional $24, $48, or $72 each and Option C $12, $24 or $36 per year, depending upon the number of persons. For individuals or families with little or no taxable income, premiums for both the Basic Plan and Options B and C may be reduced, by means of subsidies from the province. These premium reductions vary from 92 per cent to 74 per cent for the Basic Plan, and are 50 per cent for Options B and C. They apply to single persons with up to $500 taxable income, and to families with up to $1,000 taxable income in the previous year.

British Columbia.- The original government-operated British Columbia medical plan took effect in September 1965. It was administered by an agency directed by representatives of government and the medical profession. The benefits included most physicians' services as well as limited physiotherapy, special nursing, chiropractic and naturopathy. For eligible residents, the government offered subsidies totalling 90 per cent of the premium for persons with no taxable income and 50 per cent of the premium for persons with taxable income from $1 to $1,000. In addition, the government established a medical grant stabilization fund, initially of $2 million, to cover possible deficits.

The plan became one of several carriers or agencies of the British Columbia Medical Services Commission when this body was established as the public authority, as already noted, to operate a comprehensive program beginning July 1, 1968 under the federal Medical Care Act. Under this program the commission sets out criteria for population coverage, levels of benefits, and premiums to be charged, and these criteria must be adhered to by all approved non-profit carriers, which act as agents. As of mid-1968, annual premiums were $60 for single persons, $120 for a family of two, and $150 for a family of 3 or more.

Ontario.- The Ontario medical services insurance plan began paying benefits in July 1966. The plan offered to all eligible Ontario residents, on an individual and family enrolment basis, an insurance plan that covered most physicians' services.

The government pays, as a subsidy, the full premium of applicants who had had no taxable income during the preceding year, and of recipients of public assistance. It pays 50 per cent of the premium for a single applicant who had a taxable income of $500 or less; 50 per cent of the premium for a family of two persons with a total taxable income of $1,000 or less; and 60 per cent of the premium for a family of three or more persons with a total taxable income of $1,300 or less.

Annual premiums in mid-1968 were $70.80 for a single person, $141.60 for a family of two, and $177.00 for a family of three or more persons.

A limited amount of group coverage insurance is offered, but in the main, such enrolment is left to voluntary private plans.

Health care programs for welfare recipients. - Provincial programs enrolling specified categories of welfare recipients for health benefits have been in operation for several years in Ontario, Saskatchewan, Alberta, British Columbia, Nova Scotia, and Manitoba. Newfoundland has for many years operated a plan that provided care as required for persons in need.

These schemes each provided certain physicians' services benefits under special arrangements with the provincial medical association, and in the western provinces a range of other health services.

Saskatchewan, Alberta, British Columbia, and Ontario have recently introduced province-wide medical insurance schemes replacing previous provisions and providing automatic insurance coverage of physicians' services to welfare recipients. Quebec, Prince Edward Island and New Brunswick have recently set up new medical welfare plans to provide physicians' services expressly for the welfare recipients. These changes have coincided with the introduction of the Canada Assistance Plan Act and the Medical Care Act, providing for federal contributions to provincial medical insurance plans and health care services provided by provinces to persons in need. All recipients of provincial welfare assistance are covered under most of these programs. Manitoba and Nova Scotia provide coverage to selected categories of needy persons.

The range of physicians' services covered under each scheme is virtually comprehensive and includes physicians' visits in the home, office, and hospital, surgery, diagnostic and therapeutic procedures, and obstetrical care. All generally-used prescription drugs are also included in New Brunswick, Manitoba, Saskatchewan, and British Columbia. Extensive dental care and optical care are provided to all beneficiaries in the four westernmost provinces, although certain services may be subject to special authorization, to dollar limits, or both. Ontario has a basic dental care program for recipients of mothers' and dependent fathers' allowances and their children, and shares the cost of prescribed optical care, prosthetic appliances, drugs, and dental care, provided at municipal discretion. Such services as home nursing, appliances, physiotherapy, podiatry, chiropractic, and emergency transportation may also be paid under some programs, usually at the discretion and prior authorization of the provincial authority.

Subsection 5 - Services for the Disabled and the Chronically Ill

The success of rehabilitation programs for injured workers, war veterans, handicapped children, and other disability groups has encouraged more recent efforts to extend rehabilitation services to all handicapped persons. Physical medicine and rehabilitation departments have been established in the teaching hospitals and most veterans' and children's hospitals. There are about 40 children's hospitals and rehabilitation centres in the main cities; many children are also treated at general hospitals, or at rehabilitation centres that serve both adults and children. Five rehabilitation centres are operated under workmen's compensation programs.

Hospital services available to in-patients and out-patients include physical medicine, physiotherapy, occupational therapy, and social services; most of the children's hospitals and the teaching hospitals also supply speech therapy. The rehabilitation centres provide comprehensive medical, psychosocial, and vocational services to more-severely disabled persons. Provincial and community agencies, such as those providing rehabilitation and home care services, co-operate in the rehabilitation of disabled children and adults.

Most large general hospitals conduct out-patient clinics for various diseases and disabilities, for example, arthritis and rheumatism, diabetes, glaucoma, speech and hearing defects, heart diseases, and orthopedic and neurological conditions. Voluntary agencies concerned with specific disability groups such as arthritics, the blind, the deaf, children suffering from cystic fibrosis, haemophilia, or muscular dystrophy, the mentally ill or retarded, or disabled persons generally,are also broadening their rehabilitation services; these include counselling, personal aids and appliances, transportation, employment and education, and sheltered workshops, as well as participation in the provision of services for the homebound. Home care programs, under either hospital or community sponsorship, have been established in five provinces and are recognized as an essential community health service. They provide nursing, homemaker, physiotherapy and other services to the disabled, the chronically ill, the aged, and the convalescent, in their own homes. The Victorian Order of Nurses and other voluntary agencies supply home nursing services as do the local health services in several provinces.

Provincial health, welfare, and education departments and voluntary agencies are developing specialized services for physically and mentally handicapped children. Most provinces have established registries of handicapped children, of varying coverage, and these are being found increasingly useful in the

planning and co-ordination of rehabilitation services. In addition to medical rehabilitation, health departments and the crippled children's societies provide family counselling, recreation, transportation, and foster home care; travelling clinics extend periodic diagnostic and treatment services to outlying areas. Special schools or classes for various groups of handicapped children are operated by local school boards in the main cities, but most of the 15 residential schools for the deaf and the six for the blind are operated under provincial auspices.

Regional prosthetic research and training units established in rehabilitation centres in Montreal, Toronto, and Winnipeg, and the Bio-Engineering Institute of the University of New Brunswick, supported by National Health Grants, are significant developments. The transfer of prosthetic services for veterans from the Department of Veterans Affairs to the Department of National Health and Welfare on January 1, 1966,has made it possible for the provinces to extend these services to non-veterans. Artificial limbs and prosthetic appliances are made available in 12 Prosthetic Centres across Canada in accordance with provisions determined by provincial health departments. A federal-provincial program assists in meeting the extraordinary rehabilitation, maintenance, and counselling costs on behalf of children with thalidomide-induced defects.

Ten university schools offer training in physical therapy and/or occupational therapy and three provide training in audiology and speech therapy.

The Department of National Health and Welfare assists the provinces in their rehabilitation programs through the General Health Grants; in the year ended March 31, 1969, of this total of $40,370,400 made available through the General Health Grants to assist the provinces in their rehabilitation programs, $2,885,550 was specifically allocated to the Medical Rehabilitation and Crippled Children Grant. These grants are used to develop medical rehabilitation personnel through grants to the university schools and student bursaries, for equipment, and for research.

Section 4 - Emergency Health Services

In 1951 when the responsibility for civil defence was transferred from the Department of National Defence to the Department of National Health and Welfare, the latter formed the Civil Defence Health Services, a group within the department that was to make plans for health services in a wartime emergency.

In 1959, the Civil Defence Order assigned special powers and duties to several ministers to prepare, and to assist the junior governments in preparing, for war emergencies. This order was amended in 1963; it was replaced in 1965 by the Civil Emergency Measures Planning Order.

Thereupon in 1959, the Minister of National Health and Welfare established the Emergency Health Services Division in his own department; since 1961 the division has been supported by an advisory committee. Also in 1959, the Canada Emergency Measures Organization was created to co-ordinate civil defence planning. Its director was responsible to the Privy Council until 1963. At that time it was transferred to the Department of Industry under a director with the rank of deputy minister, and in 1968 again transferred to the Department of National Defence.

The Department of National Health and Welfare, through its Emergency Health Services Division, encourages the provinces to develop their own emergency health services divisions. These are organized under a provincial director who is generally assisted by a health-supplies officer and a nursing consultant. A staff medical officer represents the federal Emergency Health Services in each provincial organization.

The provincial emergency health services have four tasks. First, they ensure effective functioning of health services, so that vital health services will be maintained in an emergency or reorganized after a disaster. Secondly, they encourage local planning, and co-ordinate the local plans, for the development of emergency medical units. Thirdly, they inform and educate the public through courses in first aid to the injured and in home nursing, and train professional health workers, students, and volunteers, for their functions during an emergency. Fourthly, they dispose emergency medical units of the national stockpile at strategic locations. Since 1967 this last activity may be financially supported by the central government through the Emergency Health Services Division.

Not all provincial and municipal health departments have developed their emergency planning to such an extent that they could function in a wartime disaster. Some, however, have planned their emergency measures so that they have been able to meet peacetime disasters successfully. Many emergency medical units have been strategically disposed, and the governments generally are agreed upon the objectives of emergency health planning.

Section 5 - International Health

Canada actively assists and co-operates with the World Health Organization (WHO) and the other specialized agencies of the United Nations whose programs have a substantial health component or orientation. Canada's candidacy for re-election to the WHO Executive Board was successful by almost unanimous support at the 21st World Health Assembly. Capital and technical assistance are provided to developing countries through the Colombo Plan and other bilateral aid programs. Health training is provided for a number of persons coming to Canada each year under the various technical co-operation schemes; during 1967, 100 trainees arrived, bringing the total number of trainees in Canada during the year to 380. These persons were studying in a wide range of health disciplines under the External Aid Program, but with greatest concentration in undergraduate medicine and in public health.

Canadian experts in health legislation, health administration, nursing, and related areas undertook specific assignments abroad during the year and teachers and specialists in a number of clinical fields were provided in response to requests from developing countries. Capital assistance, primarily through the provision of cobalt beam therapy units for cancer treatment centres in the Colombo Plan area, was continued. During the year, the Advisory Team on the Viet Nam Medical Program visited Saigon and a number of other countries in Viet Nam and made recommendations regarding tuberculosis, rehabilitation, immunization, hospital equipment, and other programs, most of which have been or are in the process of being implemented.

To carry out Canada's obligations under the International Sanitary Conventions, the Department of National Health and Welfare maintains quarantine measures for ships and aircraft entering Canadian ports and provides accommodation and medical care for persons arriving in Canada who require quarantine (see p. 8).

The Department is responsible for the enforcement of regulations governing the handling and shipping of shellfish under the International Shellfish Agreement between Canada and the United States and, at the request of the International Joint Commission, participates in studies connected with control of pollution of boundary waters between Canada and the United States as well as with problems caused by air pollution. Other responsibilities include the custody and distribution of biological, vitamin, and hormone standards for WHO and certain duties in connection with the Single Convention on Narcotic Drugs, 1961, as well as Canada's representation on the Narcotic Commission of the United Nations.

PART II - PUBLIC WELFARE AND SOCIAL SECURITY

Responsibility for social welfare is shared by all levels of government. Comprehensive income-maintenance measures such as the Canada Pension Plan, old age security pensions, the guaranteed income supplement, family allowances, youth allowances, and unemployment insurance, where nation-wide co-ordination is required, are administered federally. The Federal Government gives substantial aid to the provinces in meeting the costs of public assistance and also provides services for special groups such as veterans, Indians, Eskimos, and immigrants. The Department of National Health and Welfare is generally responsible for federal welfare matters although the Departments of Veterans Affairs, Indian Affairs and Northern Development, and Manpower and Immigration operate programs for specific groups.

Administration of welfare services is primarily the responsibility of the provinces but the provision of services is often assumed by local authorities, generally with financial aid from the province.

Section 1 - Federal Welfare Programs

Subsection 1 - Canada Pension Plan

The Act establishing the Canada Pension Plan received Royal Assent on April 3, 1965 and was proclaimed in force on May 5 of the same year. The collection of contributions commenced in January 1966. In January 1967 the first benefits were paid in the form of Retirement Pensions. In February 1968 the first survivors' benefits were paid.

The Plan represents an important milestone in Canadian social development. It will enable millions of people to make financial provision for their retirement and to protect themselves and their dependents or survivors against loss of income in the event of the disability or death of the head of the family.

The Plan is universally applicable throughout Canada, except in the Province of Quebec where a comparable pension plan has been established. The Canada and Quebec Pension Plans are closely co-ordinated and operate virtually as a single program. Together, they cover almost all members of the labour force in Canada.

Benefit credits accrued under the Canada or Quebec Plans are portable thoughout Canada. A contributor who may have worked for more than one employer during his lifetime or who may be self-employed for all or part of his working life will accumulate pension credits regardless of where he may work in Canada. In addition, benefits under the Plan are payable to beneficiaries whether or not they live in Canada.

Every contributor to the Plan must have a Social Insurance Number so that his pensionable earnings may be accurately recorded for benefit purposes.

The maximum pensionable earnings for a year were $5,000 for both 1966 and 1967 and were $5,100 for 1968. In 1969, they are $5,200. The Plan provides for the automatic adjustment of maximum pensionable earnings. From 1970 to 1975, the figure of $5,200 is to be adjusted in line with changes in the Pension Index which, in turn, is based on the Consumer Price Index. Beginning in 1976, the maximum pensionable earnings for a year will be adjusted in accordance with changes in the Earnings Index which will reflect changes in average wage and salary levels in Canada.

To participate in the Plan, a person must be between the ages of 18 and 70 and earn more than $600 yearly as an employee, or at least $800 if he is self-employed. As of 1969, contributions are made on earnings between $600 and $5,200 a year in the case of both employees and self-employed persons. Employees contribute at the rate of 1.8 per cent, with a matching contribution being made by their employers, while self-employed persons contribute at the rate of 3.6 per cent. No contributions are to be made by persons while they are receiving disability pensions.

Benefits are classified under three main headings: Retirement Pensions; Survivors' Benefits, consisting of a widow's pension, a disabled widower's pension, orphans' benefits, and a lump sum death benefit; and Disability Pensions for contributors, with additional benefits for their dependent children.

Although contributions are made on annual earnings between $600 and the maxima referred to above, benefits are calculated on total earnings up to that maximum. That is, while contributions are not paid on the first $600 of annual earnings, that amount is nevertheless included in the calculation of benefits.

The earnings-related component of the benefit which a person is entitled to receive under the Canada or Quebec Pension Plan is based on the contributor's average pensionable earnings. Before this average is calculated, however, all

earnings are adjusted in line with the applicable maximum on pensionable earnings during the benefit year. Thus, when a benefit first becomes payable, the earnings on which it is based are related to the maximum on pensionable earnings at that time rather than to the maximum when the earnings were received.

In 1969, Retirement Pensions are payable to contributors who were 66 years of age or over provided that, if under age 70, they were retired from regular employment. The minimum pensionable age will be reduced to 65 in 1970. From then on Retirement Pensions will be payable to contributors who have retired from regular employment at the age of 65. In the case of contributors who have reached 70 years of age, Retirement Pensions are payable regardless of whether they are retired.

Retirement Pensions become payable at their full rates beginning in January 1976. These rates amount to 25 per cent of what the up-dated pensionable earnings of contributors have averaged since January 1, 1966, or from age 18, whichever comes later.

Contributors who become eligible for Retirement Pensions prior to 1976 receive reduced amounts. In the calculation of Retirement Pensions which commence during this period, pensionable earnings are averaged over ten years or 120 months. The only exception to this rule is where a Disability Pension has been paid, in which case the time during which that pension was in pay is deducted from the ten years, and the remaining period is then used for averaging purposes.

In the calculation of Retirement Pensions which commence after 1975, provision is made to assist the contributor who for a variety of reasons may have had periods of low or no earnings during his contributory period. This is accomplished by dropping out the number of months during which contributions may have been made after age 65, and by either using the pensionable earnings in those months in place of earlier periods of lesser or no earnings, or by dropping such pensionable earnings out of the calculation if they are less favourable to him. Also dropped out of the calculation are up to 15 per cent of the number of months he could have contributed to the Plan before age 65 and the earnings for an equal number of months. In this latter case, however, the drop-out must not reduce the number of months for averaging purposes to less than 120.

A person under 70 years of age who is in receipt of a Retirement Pension must meet an earnings test. In 1969, the maximum annual remuneration from employment which he may earn without affecting the amount of his pension is $900.

Should his yearly earnings exceed this figure, his pension is reduced as follows. When employment earnings in a year are between $900 and $1,500, the reduction in pension will equal 50 per cent of the amount by which his earnings exceed $900, up to a maximum of $300 a year. If earnings exceed $1,500, the reduction in pension will be $300, plus the actual amount that is earned over $1,500. However, the amount of his pension is not subject to reduction for any month in which the pensioner does not earn over $75. At age 70, a contributor is entitled to receive the full amount of his Retirement Pension regardless of the amount of his earnings.

Survivors' Benefits become payable in February 1968. They will be paid to or on behalf of the survivors of a deceased contributor who has made contributions for the minimum qualifying period, which is for three years for those whose benefits commence before 1975.

A woman who is widowed between ages 45 and 65 is entitled to a Widow's Pension consisting of a flat-rate component, plus 37½ per cent of her husband's Retirement Pension. The flat-rate component is equal to $25 multiplied by the ratio of the Pension Index for the year in which the contributor dies to the Pension Index for 1967. Thus, for 1968, the flat-rate component was $25.50 and for 1969 it is $26.01. Should her husband not be in receipt of a Retirement Pension at the time of his death, such a pension is calculated in prescribed manner for the purposes of computing the amount of the Widow's Pension.

If a woman is widowed under age 45, the same pension is paid provided she has dependent or disabled children or is herself disabled. If she does not meet any of these requirements, her pension is reduced by an amount equal to 1/120 for each month she is less than age 45 at the time of her husband's death. Accordingly, if a woman is widowed at age 35 or less, and has no dependent or disabled children and is not herself disabled, she will not receive a Widow's Pension until she reaches 65 years of age, unless she becomes disabled in the meantime.

A widow aged 65 or over receives a Widow's Pension equal to 60 per cent of her husband's Retirement Pension. This is true for a widow regardless of her age at the time her husband died or regardless of whether or not she was receiving a Widow's Pension before she became 65. Again, if her husband was not in receipt of a Retirement Pension at the time of his death, one is calculated in prescribed manner in order to compute the amount of the Widow's Pension.

Women who receive Widow's Pensions may also have contributed to the Canada or Quebec Pension Plan themselves and consequently may be entitled to Retirement or Disability Pensions in their

own right. In such cases, the Widow's Pension is combined with the other pension, in accordance with a prescribed formula, but the combined total cannot exceed the maximum Retirement Pension payable under the Act.

Orphan's Benefits are payable on behalf of a deceased contributor's unmarried dependent children. The rate for each of the first four children is equal to the flat-rate component of the widow's pension described above viz. $26.01 for 1969. When there are more than four children, the total of their benefits, which is divided equally among the children, is the sum of $26.01 for each of four children and half of that amount for each child in excess of four. Benefits are payable until the child reaches age 18, or up to the age of 25 years if he continues to attend school or university full time.

A Disabled Widower's Pension is payable where a widower is disabled and has been wholly or substantially dependent on his wife for financial support at the time of her death. The test of disability is the same as that described below for a person who claims a Disability Pension and the pension formula is the same as that for a disabled widow.

When a contributor dies, a lump sum Death Benefit equal to six times his monthly Retirement Pension will be paid to his estate. This benefit is subject to a maximum of 10 per cent of the maximum pensionable earnings for the year of death which, for 1969, would mean a death benefit not exceeding $520. Should a contributor not be in receipt of a Retirement Pension at the time of his death, a calculation is made in prescribed manner for purposes of establishing the amount of the Death Benefit.

Disability Pensions become payable in 1970. A contributor is considered to be disabled if he has a physical or mental disability that is so severe and likely to continue so long that he cannot regularly engage in any substantially gainful occupation. This will be determined by an assessment of the contributor's disability and employability. Disability Pensions, plus benefits for the dependent children of disabled contributors, will be available provided contributions have been made to the Plan for the required minimum period, which is for five years in the case of contributors whose Disability Pensions will commence before 1976.

The amount of the Disability Pension consists of a flat-rate payment equal to the flat-rate component of a widow's pension or to the orphan's benefit, plus 75 per cent of what the contributor's monthly Retirement Pension would have been had he reached age 65 when his Disability Pension commenced.

Benefits are payable on behalf of a disabled contributor's dependent children at the same rates and under essentially the same circumstances as the orphan's benefits mentioned above.

All monthly benefits being paid are adjusted upwards annually if the changes in the Pension Index warrant it. Benefits in payment in 1967 were increased by two per cent effective January 1968 and those in payment in 1968 were increased by two per cent effective January 1969.

Any contributor or beneficiary under the Plan has the right to appeal decisions with which he is dissatisfied. Appeals by employees and employers regarding coverage and contributions are first made to the Minister of National Revenue and, if the individual is not satisfied with the Minister's decision, he may appeal to the Pension Appeals Board whose decision is final.

For self-employed persons, appeals with reference to the assessment of their earnings for Canada Pension Plan purposes are treated in the same way as appeals under the Income Tax Act.

With respect to benefits, there is a three-stage appeal procedure; first, to the Minister of National Health and Welfare; secondly, to a Review Committee; and thirdly, to the Pension Appeals Board whose decision is final.

The legislation provides for the investment of the funds that accrue from monthly contributions, less the estimated amounts required to pay benefits and administrative costs over a three-month period. These funds are made available to each province on the basis of the relationship between the contributions made to the Plan by and on behalf of residents of that province and the total contributions made to the Plan. Funds not borrowed by the provinces are invested in federal securities.

The Canada Pension Plan is entirely self-supporting in that all benefits and all costs incurred in the administration of the program are financed solely from the contributions made by employees, employers, and self-employed persons and the interest earned from the investment of funds.

As provided for in the legislation, an Advisory Committee of 16 persons representing employers, employees, self-employed persons, and the public was established in 1967. This Committee reviews, from time to time, the overall operations of the Plan, the state of the Investment Fund, and the adequacy of coverage and benefits. The Committee's reports on its activities are made to the Minister of National Health and Welfare and are included in the Annual Reports on the Plan.

There is also authority to enter into arrangements with other countries to achieve as full coverage of persons in the labour force in Canada as is possible and to ensure the portability of pension credits between Canada and the countries concerned.

The Minister of National Health and Welfare is responsible for the administration of all parts of the program except coverage and the collection of contributions, which come under the jurisdiction of the Minister of National Revenue. The Unemployment Insurance Commission is responsible for the assignment of Social Insurance Numbers and for the maintenance of the central index. The Department of Finance is responsible for the administration of the Canada Pension Plan Account and the Canada Pension Plan Investment Fund. The office of the Comptroller of the Treasury, in addition to its statutory responsibility, is providing temporary assistance to the Department of National Health and Welfare in the operation of the electronic data processing service which is required to maintain the Records of Earnings of contributors and to calculate benefits payable under the Plan. The Chief Actuary, Department of Insurance, is responsible for the preparation of reports on the future financial progress of the Plan and on the effect on the Fund of proposed amendments to the Plan.

The Canada Pension Plan Administration of the Department of National Health and Welfare maintains a head office establishment in Ottawa and a network of 39 district offices located in the major population centres in Canada outside the Province of Quebec and 103 part-time local offices.

Subsection 2 - Old Age Security

Under the Old Age Security Act of 1951, as amended, the Federal Government pays a monthly pension to all persons who meet the necessary residence and age qualifications. In 1969, the pension is payable to qualified persons aged 66 and over and, from 1970 on, to those 65 years of age and over. Until 1967, the pension amounted to $75 a month but, in 1968 and succeeding years, the amount of the pension may be adjusted in line with changes in the Pension Index developed for the Canada Pension Plan. An adjustment, effective in January 1968, increased the amount to $76.50 a month and another, in January 1969, to $78 a month.

The old age security pension is payable to a person of attained age who has resided in Canada for ten years immediately preceding the approval of his application for the pension. Any gaps in the ten-year period may be off-set if the applicant had been present in Canada in earlier years for periods of time

equal in total to double the length of the gaps; in this case, however, the applicant must also have resided in Canada for one year immediately before his application for pension may be approved. The pension is also payable to persons of attained age who have left Canada before reaching that age but who have had 40 years of residence in Canada since age 18. A pensioner may absent himself from Canada and continue to receive payments. If he has lived in Canada for 25 years since his 21st birthday, payment outside of Canada may continue indefinitely; if not, payment is continued for six months, in addition to the month of departure, and is then suspended, to be resumed only with the month in which he returns to Canada.

The program is administered by the Department of National Health and Welfare through regional offices located in each provincial capital, to which application is made for pension. In the case of residents of the Yukon and the Northwest Territories the accounts are administered by the regional office located in Edmonton. The old age security plan is financed through a 3-p.c. sales tax, a 3-p.c. tax on corporation income and, subject to a limit of $240 a year a 4-p.c. tax on taxable personal income. The revenues from these sources are paid into a separate fund called the Old Age Security Fund, from which are paid the Old Age Security pensions and, from January 1, 1967, benefits under the Guaranteed Income Supplement program (see below).

Guaranteed Income Supplement. - An amendment to the Old Age Security Act, approved in December 1966, provides for the payment of a monthly guaranteed income supplement to Old Age Security pensioners who have little or no income other than the pension. The Guaranteed Income Supplement is limited to pensioners born on or before December 31, 1910, who by reason of age are or will be unable to benefit substantially from the Canada or Quebec Pension Plans. The program commenced on January 1, 1967.

The maximum supplement payable beginning in January 1967 was $30 per month. In any year after 1967, it is to be 40 per cent of the amount of the flat-rate Old Age Security pension. With the escalation of that pension effected in January 1968 the maximum supplement was increased to $30.60 a month and, commencing in January 1969, it was raised again to $36.20 a month.

Pensioners with only the old age security pension receive a guaranteed annual income of $1,310, for a single pensioner, and, for a married couple who are both pensioners, $2,621. This consists of the $78 a month pension and the monthly supplement of $31.20, which is subject to an income test. Pensioners with income in addition to their old age security pension may receive partial benefits.

TABLE 13 - OPERATIONS OF THE OLD AGE SECURITY FUND, YEARS ENDED MARCH 31, 1962 TO 1968

Item	1961-62	1962-63	1963-64	1964-65	1965-66	1966-67	1967-68
	$	$	$	$	$	$	$
Source of funds:							
Sales tax	284,879,239	302,238,927	331,760,067	383,151,254	522,085,844	559,515,046	544,516,013
Corporation income tax	100,125,000	115,250,000	115,750,000	145,250,000	152,250,000	149,500,000	150,000,000
Individual income tax	258,950,000	273,650,000	302,600,000	431,900,000	494,900,000	576,600,000	800,100,000
Loan from consolidated revenue fund	-	41,679,066	58,281,233	-	-	-	-
Balance brought forward	-	1,563,639	-	-	-	216,982,842	429,592,180
Total	643,954,239	734,381,632	808,391,300	960,301,254	1,169,235,844	1,502,597,888	1,924,208,193
Application of funds:							
Benefit payments	625,107,804	734,381,632	808,391,300	885,294,468	927,299,487	1,073,005,708(1)	1,388,118,945(1)
Repayment of loans to consolidated revenue fund	17,282,796	-	-	75,006,786	24,953,515	-	-
Balance carried over	1,563,639	-	-	-	216,982,842	429,592,180	536,089,248
Total	643,954,239	734,381,632	808,391,300	960,301,254	1,169,235,844	1,502,597,888	1,924,208,193

(1) Includes payments under the Guaranteed Income Supplement program amounting to $39,597,478 in 1966-67 and $234,835,151 in 1967-68.

TABLE 14 - OLD AGE SECURITY STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1968

Province and year		Pensioners in March	Net pensions paid during fiscal year
		No.	$
Newfoundland	1964	18,477	15,376,636
	1965	18,886	16,811,166
	1966	21,184	17,586,159
	1967	23,733	19,706,767
	1968	25,865	23,971,795
Prince Edward Island	1964	7,792	6,493,258
	1965	7,949	7,118,615
	1966	8,809	7,447,170
	1967	9,665	8,207,258
	1968	10,458	9,542,231
Nova Scotia	1964	44,424	37,063,710
	1965	45,014	40,399,804
	1966	49,801	42,048,599
	1967	54,690	46,533,160
	1968	59,363	52,783,504
New Brunswick	1964	32,592	27,247,749
	1965	33,262	29,780,719
	1966	36,852	30,994,768
	1967	40,565	34,358,253
	1968	44,390	39,418,789
Quebec	1964	207,917	171,996,794
	1965	214,294	189,682,327
	1966	242,865	201,031,152
	1967	275,515	228,797,146
	1968	309,447	267,445,266
Ontario	1964	352,004	292,547,198
	1965	360,888	321,064,620
	1966	402,997	337,194,513
	1967	451,069	377,628,224
	1968	507,341	412,802,015
Manitoba	1964	58,850	48,874,928
	1965	59,818	53,360,235
	1966	65,758	55,494,509
	1967	71,471	60,767,093
	1968	78,147	66,781,367
Saskatchewan	1964	60,587	50,751,907
	1965	61,257	55,063,268
	1966	66,638	56,755,191
	1967	71,892	61,478,838
	1968	77,725	66,153,435
Alberta	1964	65,746	54,835,096
	1965	67,245	60,052,938
	1966	74,514	62,793,976
	1967	82,145	69,524,557
	1968	91,118	77,574,022
British Columbia	1964	122,732	102,639,328
	1965	124,262	111,327,361
	1966	135,556	115,292,880
	1967	147,930	125,662,029
	1968	161,341	135,848,974
Yukon and Northwest Territories	1964	680	564,696
	1965	707	633,415
	1966	802	660,570
	1967	886	744,905
	1968	1,015	962,396
Canada	1964	971,801	808,391,300
	1965	993,582	885,294,468
	1966	1,105,776	927,299,487
	1967	1,229,561	1,033,408,230
	1968	1,366,210	1,153,283,794

The maximum supplement is reduced by $1 a month for every full $2 a month of income over and above the Old Age Security pension and any supplement that may have been received. Income for this purpose is the same as that computed in accordance with the Income Tax Act. In the case of a married couple, each is considered to have one-half of their combined income. Where one spouse will not be receiving an Old Age Security pension at any time in the current year, to make allowance for that fact, six times the amount of the monthly Old Age Security pension is deducted from one-half of the combined income in calculating the income of the pensioner for Guaranteed Income Supplement purposes.

Payments will not be made to married couples unless both spouses submit returns. However, in order to prevent undue hardship when no statement of income is obtainable from one spouse, the other, in certain circumstances, may be deemed to be single for purposes of determining income. Furthermore, although marital status is determined as at December 31 of the preceding year, even if this status should change in the current year, a special provision allows a person to be deemed either married or single in the preceding year.

Entitlement to a supplement is normally based on the pensioner's income in the previous year. However, where a pensioner retired from employment or self-employment in that year or in the current year, he may elect to substitute estimates of certain income items (such as employment earnings and pensions) in the current year for that which he actually received in the preceding year. This may allow him to show a lower income and hence to become eligible for a higher supplement.

If a pensioner who is in receipt of a supplement leaves Canada, the supplement will be paid for the month of departure and for six further months. If he has not returned by then, payment will be discontinued but may be paid again upon his return. If on the date when a supplement might otherwise become payable to a pensioner he has been absent from Canada for six months, no supplement may be paid until his return. If his absence has been for less than six months, a supplement may be paid until he has been away for six months. It will then be discontinued until his return.

The Guaranteed Income Supplement program is administered in conjunction with the Old Age Security pension program. An application for the supplement is sent to each person when he begins to receive the Old Age Security pension and subsequently at the beginning of each calendar year. Entitlement is reassessed each year on the basis of the pensioner's income in the preceding year.

Tables 15 to 22 provide a statistical analysis of the operations of the Guaranteed Income Supplement program.

TABLE 15 - GUARANTEED INCOME SUPPLEMENT PENSIONERS AND PAYMENTS, BY PROVINCE, YEARS ENDED MARCH 31, 1967 AND 1968

Province and year		Pensioners in March	Net Supplements Paid During Fiscal Year(1)	Province and year		Pensioners in March	Net Supplements Paid During Fiscal Year(1)
		No.	$			No.	$
Newfoundland.....	1967	18,037	1,520,404	Manitoba.....	1967	35,633	2,731,259
	1968	21,165	4,873,628		1968	44,323	13,587,590
Prince Edward Island.....	1967	6,444	521,776	Saskatchewan.....	1967	33,132	2,545,612
	1968	7,801	1,941,171		1968	40,564	13,463,882
Nova Scotia.....	1967	30,613	2,464,576	Alberta.....	1967	36,526	2,863,528
	1968	38,230	10,739,242		1968	50,267	15,788,848
New Brunswick.....	1967	21,937	1,795,836	British Columbia.....	1967	57,922	4,421,545
	1968	28,691	8,026,962		1968	79,674	27,664,511
Quebec.....	1967	136,306	10,968,346	Yukon and Northwest Territories.....	1967	51	3,127
	1968	187,943	54,423,691		1968	761	198,531
Ontario.....	1967	128,639	9,761,469	Canada.....	1967	505,240	39,597,478
	1968	215,229	84,127,095		1968	714,648	234,835,151

(1) 1967 figures cover three months; program became effective January 1, 1967.

TABLE 16 - NUMBERS AND PERCENTAGES OF THE POPULATION RECEIVING GIS AS OF JANUARY 1, 1967 AND 1968, BY SEX AND AGE.

Sex and age	As of January 1, 1967				As of January 1, 1968			
	Number	Per cent of population(1) receiving GIS and			Number	Per cent of population(2) receiving GIS and		
		Without other income(3)	With other income(3)	Total		Without other income(4)	With other income(4)	Total
Male								
67(5)	0	0.0	0.0	0.0	14,120	15.5	11.8	27.3
68	14,610	17.6	13.8	31.4	12,985	15.8	10.8	26.6
69	14,420	18.3	14.2	32.5	13,815	18.5	11.2	29.7
70 - 74	79,070	21.4	18.4	39.8	73,970	20.9	16.1	37.0
75 - 79	71,725	27.6	24.0	51.6	70,775	28.0	22.4	50.4
80 - 84	45,795	31.6	25.2	56.8	47,790	34.4	24.3	58.7
85 - 89	20,905	38.9	24.3	63.2	20,900	37.9	23.2	61.1
90 - 94	5,440	41.0	22.6	63.6	5,915	47.2	20.0	67.2
95 plus	1,320	63.1	22.0	85.1	1,175	49.7	23.7	73.4
All ages	253,285	25.3	20.5	45.8	261,445	24.7	17.9	42.6
Female								
67(5)	0	0.0	0.0	0.0	20,935	26.9	10.4	37.3
68	21,695	30.2	11.2	41.4	18,910	25.4	9.4	34.8
69	21,285	29.7	12.2	41.9	21,500	29.7	11.4	41.1
70 - 74	111,805	33.0	16.0	49.0	113,450	34.0	14.7	48.7
75 - 79	97,045	40.4	19.7	60.1	98,955	39.8	19.5	59.3
80 - 84	65,130	45.0	22.4	67.4	68,715	46.4	22.4	68.8
85 - 89	30,455	47.0	22.7	69.7	33,625	51.3	22.8	74.1
90 - 94	9,715	53.9	19.7	73.6	10,560	54.0	22.0	76.0
95 plus	2,265	63.1	16.3	79.4	2,700	73.1	16.6	89.7
All ages	359,395	37.6	17.7	55.3	389,350	37.2	16.5	53.7
Both sexes								
67(5)	0	0.0	0.0	0.0	35,055	21.4	11.1	32.5
68	36,305	24.3	12.4	36.7	31,895	20.8	10.1	30.9
69	35,705	24.3	13.2	37.5	35,315	24.4	11.3	35.7
70 - 74	190,875	27.6	17.1	44.7	187,420	28.0	15.3	43.3
75 - 79	168,770	34.5	21.7	56.2	169,730	34.5	20.8	55.3
80 - 84	110,925	38.9	23.7	62.6	116,505	41.0	23.3	64.3
85 - 89	51,360	43.6	23.3	66.9	54,525	45.5	23.0	68.5
90 - 94	15,155	48.9	20.8	69.7	16,475	51.4	21.2	72.6
95 plus	3,585	63.1	18.3	81.4	3,875	65.0	19.1	84.1
All ages	612,680	32.0	19.0	51.0	650,795	31.4	17.2	48.6

(1) Based on 1966 Census data, which give age at last birthday prior to June 1, 1966.
(2) Based on intercensal estimate of population as of June 1, 1967, by the Dominion Bureau of Statistics.
(3) That is, exclusive of Old Age Security (OAS) during the previous calendar year.
(4) That is, exclusive of OAS and GIS during the previous calendar year.
(5) Not eligible for either OAS or GIS at age 67 years in 1967.

SOURCE: 1967 and 1968 samples of GIS applications.

TABLE 17 - INCOME STATUS DURING PREVIOUS YEAR OF OAS PENSIONERS RECEIVING GIS AS OF JANUARY 1, 1967 AND 1968, BY SEX, AGE, AND MARITAL STATUS.

Sex and age	Not-married(1) pensioners				Married pensioners in two-pensioner families				Married pensioners in one-pensioner families			
	Per cent with income(2)		Average(3) income(2)		Per cent with income(2)		Average(3) income(2)		Per cent(4) with income(2)		Average(3) income(2,4)	
	1966(5)	1967	1966	1967	1966	1967	1966	1967	1966	1967	1966	1967
	%	%	$	$	%	%	$	$	%	%	$	$
Male												
67(6)	-	26.6	-	259	-	53.8	-	575	-	54.6	-	970
68	29.3	26.3	260	227	49.6	45.4	453	579	54.5	52.0	918	803
69	30.9	24.6	244	284	50.8	42.7	497	568	51.9	46.9	825	783
70 - 74	33.3	31.7	262	244	53.2	53.6	509	474	54.0	47.0	772	766
75 - 79	36.9	34.0	257	254	55.1	52.5	474	481	48.5	45.7	694	612
80 - 84	36.2	33.9	246	245	53.0	49.2	418	425	47.8	42.7	539	701
85 - 89	34.3	35.6	258	223	47.6	43.3	329	400	27.0	24.1	594	537
90 - 94	32.6	24.0	226	248	44.1	45.7	365	334	33.3*	54.5*	371	1,153*
95 plus	24.6	28.3	275	215	25.0*	55.2*	566*	257*	100.0*	50.0*	152*	303*
All ages	34.6	32.6	254	245	53.1	50.9	461	466	52.1	47.8	771	774
Female												
67(6)	-	29.1	-	283	-	26.5	-	246	-	23.2	-	439
68	30.0	29.0	281	235	24.6	24.6	216	276	12.9	18.8*	147	184*
69	33.2	32.0	229	263	23.7	21.4	262	216	9.1*	16.7	439*	175
70 - 74	35.0	32.7	259	243	27.6	27.3	207	267	18.4	18.3	248	525
75 - 79	33.8	33.5	260	238	29.7	30.6	205	201	12.5*	35.6	343*	478
80 - 84	34.1	33.2	248	237	29.2	29.7	177	232	0.*	0.0*	0*	0*
85 - 89	32.8	30.7	227	230	27.8	32.1	177	167	0.*	0.0*	0*	0*
90 - 94	27.8	29.3	207	177	20.5	21.1	190	101	- *	- *	- *	- *
95 plus	21.1	17.7	178	175	0.0*	40.0*	0*	295*	0.0*	- *	0*	- *
All ages	33.6	31.9	249	239	27.7	27.8	206	214	18.5	20.6	250	408
Both sexes												
67(6)	-	27.3	-	276	-	38.2	-	361	-	49.9	-	933
68	29.8	27.2	273	233	39.2	39.6	391	382	47.6	49.7	889	786
69	30.6	29.9	238	268	30.9	37.5	365	373	47.4	43.9	819	760
70 - 74	34.6	31.7	266	244	38.7	38.3	386	363	52.1	45.4	751	760
75 - 79	34.7	33.7	259	242	44.4	43.5	398	470	46.9	45.1	690	608
80 - 84	34.7	33.4	249	239	45.3	42.5	367	378	47.3	42.0	539	701
85 - 89	33.3	32.2	238	228	42.3	40.0	302	346	26.7	23.2	594	537
90 - 94	28.8	27.7	213	195	37.0	40.5	336	308	33.3*	54.5*	371*	1,153*
95 plus	22.3	20.6	214	190	10.5*	49.0	566*	539	50.0*	50.0*	152*	303*
All ages	33.9	32.1	252	241	40.9	39.4	377	378	49.5	45.9	756	762

(1) "Not-married pensioners" is defined as "persons who have never married, persons who are not now married because of death, divorce or legal separation, or persons whom the Minister has deemed to be not-married for purposes of the program."
(2) Excluding OAS in 1966 and OAS and GIS in 1967.
(3) Per pensioner having income.
(4) Of pensioners only.
(5) The years shown are those in which the incomes were actually received. Thus the years 1966 and 1967 refer to the 1967 and 1968 GIS recipients respectively.
(6) Not eligible for either OAS or GIS at age 67 years in 1967.
* Less than five cases with the characteristics indicated were reported in the sample.

SOURCE: 1967 and 1968 samples of GIS applications.

TABLE 18 - SOURCES AND AVERAGE AMOUNTS OF INCOME(1) FOR THE PREVIOUS YEAR, OF 1967 AND 1968 RECIPIENTS OF GIS, AND OF NON-PENSIONER SPOUSES OF 1968 RECIPIENTS, BY SEX AND MARITAL STATUS.

Source of income	Not-married pensioners(2)				Married pensioners				Non-pensioner spouses(3)	
	Male		Female		Male		Female		Female	Male
	1966(4)	1967(5)	1966(4)	1967(5)	1966(4)	1967(5)	1966(4)	1967(5)	1967(6)	1967(6)
1. Pensions, Annuities and Other Retirement Benefits										
Number(7)	7,965	6,995	12,010	12,120	27,060	25,565	1,435	1,815	(8)	(8)
Per cent of all with income(9)	7.0	6.4	10.4	10.2	23.9	23.2	1.2	1.5		
Average amount of income(10)	$380	$400	$341	$368	$745	$752	$407	$404		
2. Earnings from Employment										
Number(7)	3,960(11)	2,475	3,925(11)	2,260	13,655(11)	8,165	1,200(11)	980	4,220	955
Per cent of all with income(9)	3.5	2.2	3.4	1.9	12.1	7.4	1.0	0.8	3.8	0.8
Average amount of income(10)	$229	$245	$248	$236	$591	$549	$302	$349	$771	$938
3. Professional Fees Earned										
Number(7)	(11)	80*	(11)	140	(11)	280	(11)	60*	80*	0*
Per cent of all with income(9)		0.1*		0.1		0.3		0.1*	0.1*	0*
Average amount of income(10)		$70*		$150		$298		$355*	$346*	0*
4. Net Profits from Business										
Number(7)	(11)	1,085	(11)	1,205	(11)	5,365	(11)	500	1,020	485
Per cent of all with income(9)		1.0		0.9		4.6		0.4	0.9	0.4
Average amount of income(10)		$183		$196		$503		$235	$471	$798
5. Dividends										
Number(7)	4,650	3,120	9,470	11,495	6,660	7,010	3,085	3,015	1,070	145
Per cent of all with income(9)	4.1	2.8	8.2	9.6	5.9	6.4	2.7	2.5	1.0	0.1
Average amount of income(10)	$159	$186	$159	$163	$176	$198	$148	$151	$166	$112
6. [illegible]										
Number(7)	29,530	25,640	68,935	72,170	43,840	43,615	20,125	23,430	6,395	670
Per cent of all with income(9)	26.1	23.3	59.9	60.2	38.7	39.6	17.5	19.5	5.8	0.6
Average amount of income(10)	$181	$164	$183	$179	$226	$239	$146	$160	$191	$268

TABLE 18 - SOURCES AND AVERAGE AMOUNTS OF INCOME(1) FOR THE PREVIOUS YEAR, of 1967 AND 1968 RECIPIENTS OF GIS, AND OF NON-PENSIONER SPOUSES OF 1968 RECIPIENTS, BY SEX AND MARITAL STATUS. (Concluded)

Source of income	Not-married pensioners(2)				Married pensioners				Non-pensioner spouses(3)	
	Male		Female		Male		Female		Female	Male
	1966(4)	1967(5)	1966(4)	1967(5)	1966(4)	1967(5)	1966(4)	1967(5)	1967(6)	1967(6)
7. Net Rent										
Number(7)	2,905	2,490	9,890	7,950	9,115	7,655	2,285	2,305	1,140	120
Per cent of all with income(9)	2.6	2.1	8.6	6.3	8.0	6.8	2.0	1.9	1.0	0.1
Average amount of income(10)	$238	$178	$267	$204	$351	$356	$308	$277	$328	$319
8. Other Net Income										
Number(7)	(11)	430	(11)	780	(11)	930	(11)	260	690	540
Per cent of all with income(9)		0.4		0.7		0.8		0.2	0.6	0.5
Average amount of income(10)		$167		$208		$283		$178	$453	$739
9. All Sources										
Number with income	38,545	36,455	90,625	91,985	74,705	73,600	24,390	27,920	12,275	2,315
Average amount of income(10)	$254	$245	$249	$239	$572	$564	$208	$220	$484(12)	$830(12)

(1) Exclusive of OAS and GIS.
(2) Defined as in Table 17, footnote (1).
(3) Not available for 1966.
(4) 1966 Income of GIS recipients in pay as of January 1967 (68 years of age and over).
(5) 1967 Income of GIS recipients in pay as of January 1968 (67 years of age and over).
(6) 1967 Income of spouses of GIS recipients in pay as of January 1968 (67 years of age and over).
(7) Since a person may have income from more than one source, there is duplication and the numbers having income from each source are not additive.
(8) Not available.
(9) That is, of all pensioners of same sex, married and not-married.
(10) From the specified source, for those with income from that source.
(11) For 1966, "Earnings from Employment" includes "Professional Fees Earned", "Net Profits from Business", and "Other Net Income".
(12) Corresponding figures for 1966 were $1,038 for male non-pensioner spouses and $500 for female non-pensioner spouses.
(*) Less than five cases with the characteristics indicated were reported in the sample.

SOURCE: Based on 1967 and 1968 samples of GIS applications.

TABLE 19 - PER CENT OF RECIPIENTS OF GIS AS OF JANUARY 1, 1967 AND 1968, HAVING NO INCOME(1) IN THE PREVIOUS YEAR, BY SEX, AGE, AND MARITAL STATUS.

Sex and age	Not-married pensioners(2)		Married pensioners in two-pensioner families		Married pensioners in one-pensioner families	
	1966(3)	1967(3)	1966(3)	1967(3)	1966(3)	1967(3)
Male						
67(4)	-	73.4	-	46.2	-	45.4
68	70.7	73.7	50.4	54.6	45.5	48.0
69	69.1	75.4	49.2	57.3	48.1	53.2
70 - 74	66.7	68.3	46.8	46.4	46.0	52.9
75 - 79	63.1	66.0	44.9	47.5	51.5	54.3
80 - 84	63.8	66.1	47.0	50.8	52.2	57.3
85 - 89	65.7	64.4	52.4	56.7	73.0	75.9
90 - 94	67.4	76.0	55.9	54.3	66.7*	45.5*
95 plus	75.4	71.7	75.0*	44.8*	0.0*	50.0*
All ages	65.4	68.0	46.9	49.1	47.9	52.2
Female						
67(4)	-	70.9	-	73.5	-	76.8
68	70.0	71.0	75.4	75.4	87.1	81.2*
69	66.8	68.0	76.3	78.6	91.9*	83.3
70 - 74	65.0	68.3	72.4	72.7	72.0	81.7
75 - 79	66.2	66.5	70.3	69.4	87.2*	69.2
80 - 84	65.9	66.8	70.8	70.3	100.0*	100.0*
85 - 89	67.1	69.3	72.2	67.9	100.0*	100.0*
90 - 94	72.8	70.7	79.5	78.9	- *	- *
95 plus	73.9	82.3	100.0	60.0*	100.0*	- *
All ages	66.4	68.1	72.3	72.2	81.5	79.5
Both sexes						
67(4)	-	71.7	-	67.8	-	50.1
68	70.2	71.8	70.8	70.4	51.4	53.3
69	67.4	70.1	69.1	72.5	52.6	56.1
70 - 74	65.4	68.3	61.3	61.7	47.9	54.5
75 - 79	65.3	66.3	55.6	56.5	53.1	54.9
80 - 84	65.3	66.6	54.7	57.5	52.7	58.0
85 - 89	66.7	67.8	57.7	60.0	73.3	76.7
90 - 94	71.2	72.3	63.0	59.5	66.7*	45.5*
95 plus	77.7	79.4	80.5*	51.0	50.0*	57.0*
All ages	66.1	68.0	59.2	60.6	50.5	54.2

(1) That is, no income except OAS in 1966 and OAS and GIS in 1967.
(2) Defined as in Table 17, footnote (1).
(3) The years shown are those in which the incomes were actually received. Thus the years 1966 and 1967 refer to the 1967 and 1968 GIS recipients respectively.
(4) Not eligible for either OAS or GIS at age 67 years in 1967.

(*) Less than five cases with the characteristics indicated were reported in the sample.

SOURCE: 1967 and 1968 samples of GIS applications.

TABLE 20 - PERCENTAGE DISTRIBUTIONS OF ALL GIS RECIPIENTS AND OF THOSE WITH INCOME, AND THEIR AVERAGE INCOMES, DURING THE PREVIOUS YEAR, AS OF JANUARY 1, 1967 AND 1968, BY SEX AND AGE

Sex and age	All GIS recipients		GIS recipients with income(1)		Average income during previous year(1)			
					Of all GIS recipients		Of GIS recipients with income	
	1967	1968	1966(2)	1967(2)	1966(2)	1967(2)	1966(2)	1967(2)
	%	%	%	%	$	$	$	$
Male								
67(3)	-	5.4	-	5.5	-	316	-	731
68	5.8	5.0	5.7	4.8	300	248	681	610
69	5.7	5.3	5.6	4.7	264	228	603	605
70 - 74	31.2	28.3	32.2	29.3	248	214	538	491
75 - 79	28.3	27.1	29.5	28.6	203	191	435	429
80 - 84	18.1	18.3	17.9	17.9	157	153	356	369
85 - 89	8.3	8.0	7.1	7.2	113	114	292	300
90 - 94	2.1	2.3	1.7	1.6	97	92	272	310
95 plus	0.5	0.4	0.3	0.4	78	74	302	229
All ages	100.0	100.0	100.0	100.0	207	193	464	458
Female								
67(3)	-	5.4	-	4.9	-	78	-	279
68	6.0	4.9	5.1	4.3	70	67	256	248
69	5.9	5.5	5.4	5.0	70	69	240	249
70 - 74	31.1	29.1	31.7	28.5	80	71	245	234
75 - 79	27.0	25.4	27.6	27.1	81	76	248	230
80 - 84	18.1	17.6	18.9	18.7	80	77	239	236
85 - 89	8.5	8.6	8.6	8.6	73	69	224	224
90 - 94	2.7	2.7	2.3	2.6	55	51	206	175
95 plus	0.6	0.7	0.4	0.4	37	34	178	184
All ages	100.0	100.0	100.0	100.0	78	72	242	234
Both sexes								
67(3)	-	5.4	-	5.2	-	174	-	510
68	5.9	4.9	5.4	4.5	162	141	478	432
69	5.8	5.4	5.5	4.8	148	131	423	415
70 - 74	31.2	28.8	32.0	28.9	150	127	392	359
75 - 79	27.5	26.1	28.6	27.8	133	124	344	328
80 - 84	18.1	17.9	18.4	18.3	112	108	295	298
85 - 89	8.4	8.4	7.9	8.0	89	86	255	257
90 - 94	2.5	2.5	2.0	2.1	70	66	234	224
95 plus	0.6	0.6	0.4	0.4	52	46	230	204
All ages	100.0	100.0	100.0	100.0	131	121	352	342

(1) Excluding OAS in 1966 and OAS and GIS in 1967.
(2) The years shown in these columns are those in which the incomes were actually received. Thus, the years 1966 and 1967 refer to the 1967 and 1968 GIS recipients respectively.
(3) Not eligible for either OAS or GIS at age 67 years in 1967.

SOURCE: 1967 and 1968 samples of GIS applications.

TABLE 21 - OAS PENSIONERS BY GIS STATUS, NUMBERS AND PERCENTAGES, BY PROVINCE, JUNE 1967

Province	Number of OAS pensioners				Percentage of OAS pensioners			
	Total	Without GIS	With partial GIS	With full GIS	Total	Without GIS	With partial GIS	With full GIS
Newfoundland	23,455	3,827	3,489	16,139	100.0	16.3	14.9	68.8
Prince Edward Island	9,688	2,405	2,365	4,918	100.0	24.8	24.4	50.8
Nova Scotia	54,939	18,151	12,279	24,509	100.0	33.0	22.4	44.6
New Brunswick	40,849	13,627	7,942	19,280	100.0	33.4	19.4	47.2
Quebec	277,827	103,432	54,977	119,418	100.0	37.2	19.8	43.0
Ontario	454,964	208,793	114,845	131,326	100.0	45.9	25.2	28.9
Manitoba	71,676	29,804	17,195	24,677	100.0	41.6	24.0	34.4
Saskatchewan	72,188	32,789	17,125	22,274	100.0	45.4	23.7	30.9
Alberta	82,570	35,102	18,948	28,520	100.0	42.5	22.9	34.5
British Columbia	148,222	70,954	31,846	45,422	100.0	47.9	21.5	30.6
Northwest Territories	566	116	36	414	100.0	20.5	6.4	73.1
Yukon Territory	336	116	48	172	100.0	34.5	14.3	51.2
Canada	1,237,280	519,116	281,095	437,069	100.0	42.0	22.7	35.3

SOURCE: Monthly report, Treasury Office, Department of National Health and Welfare.

TABLE 22 - OAS PENSIONERS BY GIS STATUS, NUMBERS AND PERCENTAGES, BY PROVINCE, JUNE 1968

Province	Number of OAS pensioners				Percentage of OAS pensioners			
	Total	Without GIS	With partial GIS	With full GIS	Total	Without GIS	With partial GIS	With full GIS
Newfoundland	25,849	4,637	3,682	17,530	100.0	17.9	14.2	67.8
Prince Edward Island	10,539	2,731	2,501	5,307	100.0	25.9	23.7	50.4
Nova Scotia	59,448	20,891	12,919	25,638	100.0	35.1	21.7	43.1
New Brunswick	44,545	16,071	8,254	20,220	100.0	36.1	18.5	45.4
Quebec	312,532	120,137	57,247	135,148	100.0	38.4	18.3	43.2
Ontario	503,123	272,389	125,700	105,034	100.0	54.1	25.0	20.9
Manitoba	78,332	34,984	17,970	25,378	100.0	44.7	22.9	32.4
Saskatchewan	77,840	37,336	17,057	23,447	100.0	48.0	21.9	30.1
Alberta	91,833	41,244	20,131	30,458	100.0	44.9	21.9	33.2
British Columbia	162,457	81,613	33,539	47,305	100.0	50.2	20.6	29.1
Northwest Territories	653	122	44	487	100.0	18.7	6.7	74.6
Yukon Territory	371	141	28	202	100.0	38.0	7.5	54.4
Canada	1,367,522	632,296	299,072	436,154	100.0	46.2	21.9	31.9

SOURCE: Monthly report, Treasury Office, Department of National Health and Welfare.

Subsection 3 - Family Allowances

The Family Allowances Act of 1944 is designed to assist in providing equal opportunity for all Canadian children. The allowances do not involve a means test and are paid from the federal Consolidated Revenue Fund. They do not constitute taxable income but there is a smaller income tax exemption for children eligible for allowances. The province of Quebec introduced its own family allowances program, supplementing the federal scheme, under legislation enacted in 1967 (see p. 104)

Allowances are payable in respect of every child under the age of 16 years who was born in Canada, or who has been a resident of the country for one year, or whose father or mother has been domiciled in Canada from a date three years immediately prior to the date of birth of the child. Payment is made by cheque each month, normally to the mother, although any person who substantially maintains the child may be paid the allowance on his behalf. Allowances are paid at the monthly rate of $6 for each child under 10 years of age and $8 for each child aged 10 or over but under 16 years. If the allowances are not spent for the purposes outlined in the Act, payment may be discontinued or made to some other person or agency on behalf of the child. Allowances are not payable for any child who fails to comply with provincial school or attendance legislation, who ceases to be maintened by a parent, who ceases to be a resident of Canada, or on behalf of a girl who is married and under 16 years of age.

The program is administered by the Department of National Health and Welfare through regional offices located in each provincial capital. The Regional Director located at Edmonton also administers the accounts of residents in the Yukon and Northwest Territories.

The federal government pays family assistance, at the rates applicable for family allowances, for each child under 16 years of age resident in Canada and supported by an immigrant who has landed for permanent residence in Canada, or by a Canadian returned to Canada to reside permanently. The assistance, which is payable monthly for the first year of the child's residence in Canada, is intended to bridge the gap until the child becomes eligible for family allowances. The eligibility requirements, other than that relating to length of residence, are the same for family assistance as for family allowances.

In 1966, the Province of Newfoundland introduced a scheme called the Parents Supplement (Selecting Allowances) Program (see p. 104).

TABLE 23 - FAMILY ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1968

Province and year	Families receiving allowance in March	Children for whom allowance paid in March	Average number of children per family in March	Average allowance(1)		Net total allowances paid during fiscal year
				Per family	Per child	
	No.	No.	No.	$	$	$
Newfoundland..... 1964	67,635	209,180	3.09	20.75	6.71	16,747,021
1965	68,418	210,016	3.07	20.59	6.71	16,871,056
1966	69,346	210,512	3.04	20.40	6.71	16,945,059
1967	70,435	210,082	2.98	20.08	6.73	16,960,053
1968	72,041	210,812	2.93	19.70	6.73	16,983,302
Prince Edward Island..... 1964	14,377	40,524	2.82	19.05	6.76	3,274,057
1965	14,191	40,201	2.83	19.12	6.75	3,266,459
1966	14,054	39,632	2.82	19.03	6.75	3,231,716
1967	14,099	39,342	2.79	18.81	6.74	3,190,484
1968	14,236	39,100	2.75	18.60	6.77	3,178,692
Nova Scotia..... 1964	105,754	271,336	2.57	17.20	6.70	21,790,680
1965	105,163	269,845	2.57	17.24	6.72	21,776,091
1966	104,856	267,689	2.55	17.18	6.74	21,636,528
1967	105,214	264,998	2.52	17.01	6.75	21,507,992
1968	106,712	263,340	2.47	16.73	6.78	21,410,766
New Brunswick..... 1964	82,711	237,093	2.87	19.29	6.73	19,198,184
1965	82,578	235,714	2.85	19.24	6.74	19,069,036
1966	82,851	233,724	2.82	19.08	6.76	18,982,908
1967	82,929	229,798	2.77	18.76	6.77	18,752,034
1968	84,108	227,747	2.71	18.37	6.79	18,595,852
Quebec..... 1964	766,364	2,017,190	2.63	17.74	6.74	162,172,423
1965	780,305	2,037,605	2.61	17.60	6.74	163,888,091
1966	792,955	2,043,428	2.57	17.38	6.76	164,972,052
1967	805,315	2,034,966	2.53	17.10	6.77	165,095,827
1968	818,220	2,025,173	2.48	16.78	6.78	164,637,234
Ontario..... 1964	949,955	2,209,982	2.33	15.56	6.69	175,544,729
1965	964,468	2,248,642	2.33	15.65	6.71	179,056,316
1966	983,502	2,284,059	2.32	15.61	6.73	182,377,587
1967	1,007,038	2,308,919	2.29	15.48	6.75	185,309,485
1968	1,029,734	2,329,769	2.26	15.30	6.76	187,635,949

(1) Based on gross payment for March.

TABLE 23 - FAMILY ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1968 (Concluded)

Province and year	Families receiving allowance in March	Children for whom allowance paid in March	Average number of children per family in March	Average allowance(1)		Net total allowances paid during fiscal year
				Per family	Per child	
	No.	No.	No.	$	$	$
Manitoba..... 1964	133,105	321,413	2.41	16.17	6.69	25,727,440
1965	133,500	323,862	2.43	16.24	6.69	25,926,570
1966	132,148	321,747	2.43	16.30	6.71	25,925,991
1967	131,011	315,166	2.41	16.26	6.76	25,651,443
1968	131,098	312,777	2.39	16.12	6.76	25,432,808
Saskatchewan..... 1964	131,240	333,051	2.53	16.97	6.69	26,650,259
1965	131,449	335,381	2.55	17.09	6.70	26,891,288
1966	131,266	332,952	2.54	17.11	6.74	26,988,369
1967	130,876	330,015	2.52	17.05	6.76	26,870,934
1968	131,164	326,957	2.49	16.90	6.78	26,710,541
Alberta..... 1964	211,105	519,140	2.46	16.47	6.70	41,227,721
1965	212,630	525,976	2.47	16.57	6.70	41,996,327
1966	213,489	525,859	2.46	16.58	6.74	42,345,742
1967	216,086	527,411	2.44	16.50	6.76	42,563,978
1968	220,778	531,409	2.41	16.35	6.79	42,990,910
British Columbia..... 1964	242,789	561,174	2.31	15.51	6.71	44,712,129
1965	247,635	573,714	2.32	15.58	6.73	45,745,199
1966	254,871	589,041	2.31	15.60	6.75	47,006,572
1967	264,480	605,443	2.29	15.50	6.77	48,525,782
1968	273,093	616,519	2.26	15.34	6.80	49,773,623
Yukon and Northwest Territories..... 1964	6,237	16,074	2.58	17.21	6.68	1,267,581
1965	6,212	16,057	2.58	17.19	6.65	1,288,798
1966	6,298	16,414	2.61	17.21	6.60	1,322,300
1967	6,458	16,734	2.59	17.84	6.88	1,366,935
1968	6,917	17,883	2.59	17.71	6.85	1,424,781
Canada..... 1964	2,711,272	6,736,157	2.48	16.67	6.72	538,312,224
1965	2,746,549	6,817,013	2.48	16.68	6.72	545,779,281
1966	2,785,636	6,865,057	2.46	16.79	6.74	551,734,824
1967	2,833,941	6,882,874	2.43	16.84	6.76	555,794,947
1968	2,888,101	6,901,486	2.39	16.19	6.77	558,774,458

(1) Based on gross payment for March.

Subsection 4 - Youth Allowances

Legislation providing for a program of youth allowances became effective September 1, 1964. The Federal Government does not provide youth allowances in Quebec, which has had its own program called schooling allowances since 1961. With the introduction of the federal scheme, Quebec agreed to make certain changes in its schooling allowances program so that it would be comparable to the federal measure; since then that province has been compensated by a tax abatement adjusted to equal the amount that the federal government would otherwise have paid in allowances to Quebec residents. The federal youth allowances and the Quebec schooling allowances programs cover all eligible young people in Canada.

Under the federal program monthly allowances of $10 are payable in respect of all dependent children aged 16 and 17 who are receiving full-time educational training or are precluded from doing so by reason of physical or mental infirmity. Both the parent or guardian and the child must normally be physically present and living in a province other than Quebec. The allowance is not payable to a parent who resides in Quebec or outside Canada, regardless of where his child may be attending school. However, a child may attend school in Quebec or outside Canada or, if disabled, receive care or training in Quebec or outside Canada, and still be considered eligible, on the basis that he is a resident of a province other than Quebec but is temporarily absent.

Allowances normally commence with the month following that in which family allowances cease and continue until the school year terminates. They are paid retroactively for the summer months when the child returns to school at the commencement of the new school year, although allowances for a disabled child not attending school are payable continuously throughout the year. Should a student leave school, leave the country permanently, cease to be maintained, take up residence in Quebec, or die, the allowance will cease. Otherwise, the youth allowance continues until the end of the month in which the young person reaches age 18. Youth allowances are considered not to be income for any purpose of the Income Tax Act.

The program is administered by the Department of National Health and Welfare. The national director of the family allowances and old age security programs is also responsible for administering youth allowances, assisted by regional directors located in each of the provincial capitals other than Quebec City. The costs of youth allowances are met from the Consolidated Revenue Fund.

TABLE 24 - YOUTH ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1965 TO 1968

Province and year		Youths for whom allowance paid in March			Net total allowance paid during fiscal year(1)
		Attending school full-time	Having physical or mental infirmity	Total youths	
		No.	No.	No.	$
Newfoundland	1965	13,673	125	13,798	881,777
	1966	14,970	151	15,121	1,591,901
	1967	15,527	157	15,684	1,686,661
	1968	15,867	157	16,024	1,747,142
Prince Edward Island	1965	3,391	44	3,435	231,142
	1966	3,553	40	3,593	395,465
	1967	3,432	38	3,470	397,505
	1968	3,347	33	3,380	392,096
Nova Scotia	1965	23,385	164	23,549	1,590,976
	1966	22,972	176	23,148	2,691,768
	1967	22,938	192	23,130	2,654,786
	1968	23,518	155	23,673	2,697,524
New Brunswick	1965	19,885	194	20,079	1,352,716
	1966	19,868	204	20,072	2,311,244
	1967	19,878	199	20,077	2,300,043
	1968	20,689	151	20,840	2,361,241
Ontario	1965	186,988	725	187,713	12,652,036
	1966	189,923	783	190,706	21,978,399
	1967	192,861	1,234	194,095	22,491,673
	1968	207,176	1,399	208,575	23,763,161
Manitoba	1965	28,017	106	28,123	1,916,217
	1966	27,930	148	28,078	3,249,490
	1967	27,775	134	27,909	3,242,828
	1968	28,708	125	28,833	3,293,702
Saskatchewan	1965	29,146	107	29,253	1,990,364
	1966	29,605	94	29,699	3,414,834
	1967	29,718	86	29,804	3,434,721
	1968	30,424	86	30,510	3,487,264
Alberta	1965	41,297	154	41,451	2,806,661
	1966	41,877	181	42,058	4,836,771
	1967	42,868	235	43,103	4,960,783
	1968	44,934	195	45,129	5,148,230
British Columbia	1965	50,002	137	50,139	3,415,086
	1966	51,556	214	51,770	5,934,292
	1967	54,039	252	54,291	6,159,249
	1968	56,731	208	56,939	6,462,040
Yukon	1965	258	-	258	17,060
	1966	258	1	259	30,210
	1967	243	1	244	28,044
	1968	280	-	280	29,340
Northwest Territories	1965	235	-	235	15,780
	1966	290	-	290	34,176
	1967	312	2	314	39,340
	1968	377	5	382	45,240
Total	1965	[illegible]	[illegible]	398,033	26,869,815
	1966	402,802	1,992	[illegible]	[illegible]
	1967	409,591	2,530	412,121	47,395,633
	1968	432,051	2,514	434,565	49,426,980

(1) 1965 figures cover seven months; program became effective September 1, 1964.

Section 2 - Federal-Provincial Welfare Programs

Subsection 1 - Canada Assistance Plan

The Canada Assistance Plan was enacted in 1966 as a comprehensive public assistance measure to complement other income security measures. It provides, under agreements with the provinces, federal contributions of 50 per cent of the costs of assistance to persons in need and of the costs of the welfare services described below.

The Canada Assistance Plan is designed to replace the Unemployment Assistance Act, 1956, although the latter will continue in effect in some provinces for an interim period with respect to certain programs that utilize a means test and are not covered under the Canada Assistance Plan. Under the terms of the Canada Assistance Plan legislation, the provinces may discontinue the receipt of applications under the programs of old age assistance, blind persons allowances and disabled persons allowances and provide instead aid under their general programs, with costs shared under the Canada Assistance Plan.

Five provinces (Newfoundland, Prince Edward Island, Ontario, Saskatchewan, and Alberta) no longer receive applications for Old Age Assistance or disabled persons allowances and three of these (Ontario, Saskatchewan, and Alberta) have discontinued receipt of applications for blind persons allowances also. In these provinces, however, these categorical programs will continue in effect for those persons who are not eligible for transfer to the general program.

All provinces, but neither territory, had signed agreements under the Canada Assistance Plan by the end of August 1967. The arrangements for contracting out of certain shared-cost programs that were introduced in 1965 under the Established Programs (Interim Arrangements) Act are applied to Quebec's agreement under the Plan.

Effective from April 1, 1966, the Canada Assistance Plan extends federal sharing to include the following costs, which were not shared under the Unemployment Assistance Act: the cost of assistance to needy mothers with dependent children, maintenance of children in the care of provincially approved child welfare agencies, health care services to needy persons, and the extension of welfare services to prevent or remove causes of dependency or to assist recipients in achieving self-support. Health care services may include

medical, surgical, obstetrical, optical, dental, and nursing services; drugs; dressings; prosthetic appliances; and other items associated with the provision of such services. Welfare services may include rehabilitation services; casework; counselling and assessment services; adoption services; and homemaker, day-care, and similar services supplied to persons in need or to persons to whom the service is essential if they are to remain self-supporting.

The only eligibility requirement specified in the Canada Assistance Plan is that of need, which is to be determined through an assessment of budgetary requirements as well as of income and resources. A province must not require previous residence as a condition of eligibility for assistance or for continued assistance. Rates of assistance and eligibility requirements are set by the province. The Plan thus enables the provinces to adjust their rates to local conditions and to take into account the needs of special groups. It requires that the provinces establish procedures for appeal from decisions that relate to the provision of assistance.

The Federal Government reimburses the provinces for 50 per cent of the cost of assistance provided to persons in need and for 50 per cent of certain costs of improving or extending welfare services.

"Assistance" comprises any form of aid to or in behalf of persons in need for the purpose of providing basic requirements such as food, shelter, and clothing; items necessary for the safety, well-being, or rehabilitation of a person in need, such as special food or clothing, telephone, rehabilitation allowance, or items necessary for a handicapped person; care in a home for special care such as a home for the aged, a nursing home, or a welfare institution for children; travel and transportation; funerals and burials; health care services; welfare services purchased by or at the request of provincially approved agencies; and comfort allowances for inmates of institutions.

The cost of improving and extending welfare services may be calculated either (1) as the amount by which the cost of providing welfare services exceeds that of the period from April 1, 1964 to March 31, 1965 or (2) as the cost of employing persons who are engaged wholly or mainly in the performance of welfare service functions and who are employed in positions filled after March 31, 1965. No province has followed the second alternative. Included for sharable purposes are the costs of salaries and employee benefits, travel, research, consultation, fees for conferences and seminars, and certain costs of staff training whether incurred by the province or by the municipalities.

The sharing of costs of work activity projects that prepare persons for employment and of the extension of provincial welfare services to Indians on reserves, on Crown lands, or in unorganized territory, is governed by special agreements.

Federal payments under the Canada Assistance Plan amounted to $10.5 million in the fiscal year 1966-67 and to $225.6 million in 1967-68 (see Table 25).

As noted above, all programs under which aid is based on a needs test are included for reimbursement under the Canada Assistance Plan under which all provinces have signed agreements. The Unemployment Assistance Act remains in effect in the territories and, for a transitional period, in some provinces to cover the costs of aid to residual groups of persons under certain means test programs during the process of conversion to needs test programs.

Under the Unemployment Assistance Act the federal government was authorized to enter into an agreement with any province to reimburse it for 50 per cent of the unemployment assistance expenditures made by the province and its municipalities to persons and their dependents who are unemployed and in need. Payments to both employable and unemployable persons are sharable, as are the costs of maintaining persons in homes for special care, such as nursing homes and homes for the aged, and the costs of supplementary aid to recipients of old age security pensions, old age assistance, blind persons' allowances, disabled persons' allowances and unemployment insurance benefits where the amount of assistance is determined on the basis of need. Federal sharing was extended to mothers' allowances from April 1, 1966.

During the year ended March 31, 1967, the federal government made payments amounting to $141,633,582 for unemployment assistance (see Table 26). For the year ended March 31, 1968, federal payments were reduced to $26 as claims under the Canada Assistance Plan became effective.

Subsection 2 - Old Age Assistance

The Old Age Assistance Act of 1951, as amended, provides for federal reimbursement to the provinces for assistance to persons age 65 or over who are in need and who meet the ten years' residence and income requirements. For an unmarried person, total income allowed, including assistance, may not exceed $1,260 a year. For a married couple, it may not exceed $2,220 a year or, when the spouse is blind within the meaning of the Blind Persons' Act, $2,580 a year.

TABLE 25 - CANADA ASSISTANCE PLAN STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1968

Province	Federal Share of Canada Assistance Plan Costs(1)
	$
Newfoundland	17,901,873
Prince Edward Island	1,738,858
Nova Scotia	10,263,995
New Brunswick	7,185,018
Quebec	(2)
Ontario	100,287,774
Manitoba	15,571,938
Saskatchewan	13,403,926
Alberta	26,538,313
British Columbia	32,719,712
Canada	225,611,407

(1) Includes costs of child welfare maintenance, health care, and extensions and improvements in welfare services. Includes payments made for claims received in 1967-68 covering expenditures made in 1966-67.

(2) Quebec withdrew from this program under the terms of the Established Programs (Interim Arrangements) Act under which compensation is provided in the form of a tax abatement and equalization payment.

TABLE 26 - UNEMPLOYMENT ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1967

Province and year		Recipients(1) in March	Federal share of unemployment assistance costs(2)
		No.	$
Newfoundland.....	1964	59,090	4,565,680
	1965	58,931	4,620,079
	1966	51,604	4,484,744
	1967	35,515	9,406,953
Prince Edward Island.....	1964	2,924	292,832
	1965	2,628	350,059
	1966	2,914	400,823
	1967	4,615	1,063,868
Nova Scotia.....	1964	27,565	1,798,653
	1965	26,737	1,878,492
	1966	26,016	1,937,699
	1967	(3)	2,854,586
New Brunswick.....	1964	31,114	1,743,488
	1965	24,450	1,559,368
	1966	25,636	1,514,513
	1967	(3)	1,984,495
Quebec.....	1964	253,295	39,130,901
	1965	248,459	41,877,054
	1966	258,457	22,587,058(4)
	1967	386,282	39,886,899(4)
Ontario.....	1964	140,066	24,350,089
	1965	135,347	25,812,190
	1966	134,824	28,318,209
	1967	67,052(5)	37,644,727

(1) Includes dependents and for 1966-67, recipients of mothers' allowances.

(2) Payment figures shown are for the months to which the claims made under the program relate and include amounts paid to the provinces by the federal government after the end of the fiscal year.

(3) Provincial programs transferred to the Canada Assistance Plan effective January 1, 1967. The number of recipients in December 1966 in Nova Scotia was 22,474 and in New Brunswick, 33,034.

(4) During 1965-66 Quebec claims were reduced by the amount of $20,149,002 and during 1966-67 by $26,562,595 representing the federal welfare portion of cost for which compensation was provided in the form of a tax abatement.

(5) The numbers of recipients for February and March 1967 were substantially lower than those for previous months, reflecting the transfer of claims to the Canada Assistance Plan.

TABLE 26 - UNEMPLOYMENT ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1967 (Concluded)

Province and year		Recipients(1) in March	Federal share of unemployment assistance costs(2)
		No.	$
Manitoba	1964	31,282	4,952,050
	1965	31,446	5,203,784
	1966	30,806	5,718,057
	1967	14,394	6,581,817
Saskatchewan	1964	41,880	4,614,614
	1965	40,600	4,578,307
	1966	36,810	4,218,635
	1967	(3)	6,637,032
Alberta	1964	51,048	7,981,780
	1965	60,653	9,707,440
	1966	62,783	11,055,266
	1967	48,031	13,238,864
British Columbia	1964	93,763	16,918,569
	1965	92,192	17,177,860
	1966	93,904	20,104,665
	1967	85,074	22,167,099
Yukon	1964	352	67,392
	1965	322	71,509
	1966	309	71,577
	1967	380	91,268
Northwest Territories	1964	1,110	81,926
	1965	1,179	96,672
	1966	1,338	62,514
	1967	1,408	75,974
Canada	1964	733,489	106,497,974
	1965	722,944	112,932,814
	1966	725,401	100,473,760
	1967	642,751	141,633,582

(1) Includes dependents.
(2) Payment figures shown are for the months to which the claims made under the program relate and include amounts paid to the provinces by the federal government after the end of the fiscal year.
(3) The program transferred to Canada Assistance Plan in February 1967. The number of recipients in January 1967 was 32,511.

TABLE 27 - OLD AGE ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1968

Province and year		Recipients in March	Average amount of monthly assistance	Federal government contribution during year(1)
		No.	$	$
Newfoundland.....	1964	5,081	62.79	1,945,021
	1965	5,088	72.41	2,220,908
	1966	4,080	72.14	2,121,068
	1967	3,110	71.69	1,675,756
	1968	844	66.24	985,356
Prince Edward Island.....	1964	1,130	60.38	394,947
	1965	1,229	70.43	508,587
	1966	988	70.73	498,378
	1967	712	70.35	390,463
	1968	206	70.60	205,734
Nova Scotia.....	1964	5,509	69.11	2,084,088
	1965	5,574	68.53	2,302,860
	1966	4,423	67.96	2,188,257
	1967	3,134	68.39	1,667,068
	1968	1,879	66.20	1,089,056
New Brunswick.....	1964	5,447	70.96	2,121,388
	1965	5,356	70.28	2,303,178
	1966	4,200	69.72	2,161,779
	1967	3,033	70.06	1,620,148
	1968	1,957	71.27	1,139,781
Quebec.....	1964	38,206	60.96	13,860,075
	1965	39,239	70.35	16,589,045
	1966	(2)	(2)	(2)
	1967	(2)	(2)	(2)
	1968	(2)	(2)	(2)
Ontario.....	1964	25,197	67.59	9,134,698
	1965	26,049	67.03	10,465,257
	1966	19,991	67.28	10,006,001
	1967	13,279	67.04	7,238,584
	1968	1,340	59.47	1,366,432

(1) Maximum assistance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(2) Effective April 1, 1965, payments were made to Quebec under the Established Programs (Interim Arrangements) Act.

TABLE 27 - OLD AGE ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1968 (Concluded)

Province and year		Recipients in March	Average amount of monthly assistance	Federal government contribution during year(1)
		No.	$	$
Manitoba	1964	5,436	70.06	2,105,940
	1965	5,520	69.15	2,329,362
	1966	4,241	69.02	2,188,141
	1967	2,956	68.73	1,611,858
	1968	1,647	67.49	1,038,975
Saskatchewan	1964	5,549	68.59	2,151,490
	1965	5,463	69.04	2,294,105
	1966	3,975	68.87	2,097,642
	1967	1,496	67.62	1,131,452
	1968	39	58.53	295,865
Alberta	1964	6,644	69.56	2,559,785
	1965	6,810	69.00	2,901,039
	1966	6,453	68.61	2,795,633
	1967	3,617	65.62	2,092,389
	1968	1,710	66.08	1,256,491
British Columbia	1964	6,864	72.01	2,781,892
	1965	6,829	71.82	2,991,013
	1966	5,478	71.74	2,836,336
	1967	4,074	72.18	2,252,115
	1968	2,377	70.54	1,520,674
Yukon	1964	31	65.00	12,113
	1965	31	75.00	13,880
	1966	26	75.00	13,553
	1967	15	74.73	8,826
	1968	9	75.00	5,725
Northwest Territories	1964	147	64.40	56,743
	1965	166	74.32	71,721
	1966	133	73.64	73,722
	1967	120	72.75	62,085
	1968	75	73.09	46,418
Canada	1964	105,241	65.72	39,208,181
	1965	107,354	69.43	44,990,955
	1966	52,988(2)	68.85(2)	26,980,510(2)
	1967	35,546(2)	68.52(2)	19,750,744(2)
	1968	12,083(2)	66.94(2)	8,950,507(2)

(1) Maximum assistance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(2) Excludes Quebec.

A recipient is transferred to Old Age Security on reaching the eligible age for it, which in 1968 was 67 years (see p. 57). The federal contribution may not exceed 50 per cent of $75 a month or of the assistance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of assistance payable, the maximum income allowed, and other conditions of eligibility. Effective April 1, 1965, Quebec withdrew from this federal-provincial program under the Established Programs (Interim Arrangements) Act, which entitles the province to a tax abatement and an equalization payment.

Under the terms of the Canada Assistance Plan a province may elect to aid needy persons over 65 years of age under a general assistance program with costs shared under the Canada Assistance Plan (see p. 76). In accordance with this provision several provinces no longer accept applications under the Old Age Assistance program. They may also transfer current recipients of old age assistance to their general programs, provided that there is no decrease in benefits. By mid-1968, five provinces (Newfoundland, Prince Edward Island, Ontario, Saskatchewan, and Alberta) had discontinued acceptance of applications under this program.

Subsection 3 - Allowances for Blind Persons

The Blind Persons Act of 1951, as amended, provides for federal reimbursement to the provinces for allowances to blind persons age 18 or over who meet the ten-years'-residence and income requirements. For an unmarried person, total income including the allowance may not exceed $1,500 a year; for a person with no spouse but with one or more dependent children, $1,980; for a married couple, $2,580. When the spouse is also blind, income of the couple may not exceed $2,700.

The federal contribution may not exceed 75 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable and the maximum income allowed. Effective April 1, 1965, Quebec withdrew from this federal-provincial program under the Established Programs (Interim Arrangements) Act, which entitles the province to a tax abatement and an equalization payment.

Under the terms of the Canada Assistance Plan a province may elect to aid needy blind persons under a general assistance program with costs shared under the Canada Assistance Plan (see p. 76). In accordance with this provision several provinces no longer accept applications under the Blind Persons Allowance Act. They may also transfer current recipients of blind persons allowances to their general programs, provided that there is no decrease in benefits. By mid-1968 three provinces (Ontario, Saskatchewan, and Alberta) had discontinued receipt of applications under this program.

TABLE 28 - BLINDNESS ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1968

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(1)
		No.	$	$
Newfoundland.....	1964	436	63.66	246,924
	1965	460	73.49	300,474
	1966	445	73.27	304,203
	1967	438	72.98	292,224
	1968	417	73.18	285,162
Prince Edward Island.....	1964	79	64.43	46,778
	1965	71	73.47	51,020
	1966	72	72.92	47,372
	1967	67	72.92	46,142
	1968	69	73.72	45,639
Nova Scotia.....	1964	775	73.00	468,866
	1965	750	73.41	509,671
	1966	714	72.72	487,504
	1967	682	73.19	466,060
	1968	636	73.28	440,422
New Brunswick.....	1964	679	73.77	418,037
	1965	679	74.10	456,965
	1966	626	73.35	438,437
	1967	589	73.44	407,930
	1968	536	73.52	371,888
Quebec.....	1964	2,855	63.65	1,642,869
	1965	2,843	73.47	1,892,813
	1966	(2)	(2)	(2)
	1967	(2)	(2)	(2)
	1968	(2)	(2)	(2)
Ontario.....	1964	1,902	67.59	1,045,329
	1965	1,906	67.93	1,179,138
	1966	1,820	67.54	1,153,040
	1967	1,710	67.09	1,081,629
	1968	435	54.27	259,748

(1) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(2) Effective April 1, 1965, payments were made to Quebec under the Established Programs (Interim Arrangements) Act.

TABLE 28 - BLINDNESS ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1968 (Concluded)

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(1)
		No.	$	$
Manitoba	1964	383	72.67	230,264
	1965	401	72.66	258,946
	1966	364	72.19	251,385
	1967	325	72.58	226,219
	1968	294	71.91	200,718
Saskatchewan	1964	406	71.51	246,010
	1965	391	72.02	256,063
	1966	366	71.74	248,004
	1967	272	71.60	204,547
	1968	131	68.86	110,352
Alberta	1964	465	72.65	278,014
	1965	475	72.36	311,992
	1966	448	72.38	307,676
	1967	412	71.89	284,078
	1968	376	73.02	258,007
British Columbia	1964	551	73.93	335,593
	1965	556	73.15	372,208
	1966	532	73.30	358,287
	1967	484	73.60	336,639
	1968	451	73.81	315,769
Yukon	1964	4	65.00	1,999
	1965	5	75.00	2,666
	1966	6	75.00	3,994
	1967	5	75.00	3,881
	1968	6	75.00	3,460
Northwest Territories	1964	46	64.14	27,214
	1965	49	74.39	32,746
	1966	44	75.00	32,310
	1967	38	75.00	28,069
	1968	33	74.24	23,083
Canada	1964	8,581	68.12	4,987,897
	1965	8,586	72.10	5,624,702
	1966	5,437(2)	71.05(2)	3,632,212(2)
	1967	5,022(2)	70.94(2)	3,377,418(2)
	1968	3,384(2)	70.62(2)	2,314,248(2)

(1) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.

(2) Excludes Quebec.

Subsection 4 - Allowances for Disabled Persons

The Disabled Persons Act of 1954, as amended, provides for federal reimbursement to the provinces for allowances paid to permanently and totally disabled persons age 18 or over who are in need and who meet the required definition of "permanent and total disability", the ten-years'-residence requirement and specified income limits. For an unmarried person, total income including the allowance may not exceed $1,260 a year. For a married couple the limit is $2,220 a year except that, if the spouse is blind within the meaning of the Blind Persons Act, income of the couple may not exceed $2,580 a year.

The federal contribution may not exceed 50 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable, the maximum income allowed and other conditions of eligibility. Effective April 1, 1965, Quebec withdrew from this federal-provincial program under the Established Programs (Interim Arrangements) Act, which entitles the province to a tax abatement and an equalization payment.

Under the terms of the Canada Assistance Plan a province may elect to aid needy disabled persons under a general assistance program with costs shared under the Canada Assistance Plan (see p. 76). In accordance with this provision several provinces no longer accept applications under the Disabled Persons Allowances Act. They may also transfer current recipients of disabled persons allowances to their general programs, provided that there is no decrease in benefits. By mid-1968 five provinces (Newfoundland, Prince Edward Island, Ontario, Saskatchewan, and Alberta) had discontinued acceptance of applications under this program.

TABLE 29 - DISABLED PERSONS' ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1968

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(1)
		No.	$	$
Newfoundland	1964	1,586	64.53	587,092
	1965	1,746	74.63	750,279
	1966	1,817	74.49	804,197
	1967	1,873	74.55	833,340
	1968	1,393	74.43	465,500
Prince Edward Island	1964	801	64.47	310,817
	1965	797	74.31	360,150
	1966	788	74.25	349,881
	1967	814	74.35	368,992
	1968	78	72.08	176,869
Nova Scotia	1964	3,108	73.79	1,229,805
	1965	3,329	73.88	1,446,725
	1966	3,474	73.92	1,524,103
	1967	3,522	73.88	1,584,061
	1968	3,482	73.53	1,564,079
New Brunswick	1964	2,141	74.39	859,995
	1965	2,263	74.36	987,471
	1966	2,320	74.34	1,030,637
	1967	2,266	74.36	1,041,900
	1968	2,265	74.33	1,015,796
Quebec	1964	20,753	64.29	8,081,258
	1965	20,171	74.23	9,090,736
	1966	(2)	(2)	(2)
	1967	(2)	(2)	(2)
	1968	(2)	(2)	(2)
Ontario	1964	15,938	73.43	6,182,921
	1965	17,222	73.23	7,378,219
	1966	18,406	73.10	7,823,576
	1967	19,800	72.02	8,377,469
	1968	2,401	64.97	1,096,998

1) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.
2) Effective April 1, 1965, payments were made to Quebec under the Established Programs (Interim Arrangements) Act.

TABLE 29 - DISABLED PERSONS' ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1964 TO 1968 (Concluded)

Province and year		Recipients in March	Average amount of monthly allowance	Federal government contribution during year(1)
		No.	$	$
Manitoba	1964	1,518	74.09	615,287
	1965	1,538	73.96	679,916
	1966	1,566	73.80	688,650
	1967	1,547	73.91	687,543
	1968	1,498	73.64	671,508
Saskatchewan	1964	1,657	74.27	669,042
	1965	1,780	74.18	784,700
	1966	1,871	74.08	824,777
	1967	390(2)	70.94	189,817
	1968	272	69.01	129,610
Alberta	1964	1,815	73.44	727,595
	1965	1,874	73.56	830,170
	1966	1,933	73.18	851,833
	1967	1,931	72.89	859,166
	1968	1,925	72.75	844,821
British Columbia	1964	2,319	74.04	929,723
	1965	2,336	73.94	1,037,484
	1966	2,385	73.86	1,061,500
	1967	2,422	73.75	1,071,978
	1968	2,445	73.59	1,086,330
Yukon	1964	3	68.33	2,262
	1965	2	75.00	1,148
	1966	2	75.00	900
	1967	2	75.00	900
	1968	3	75.00	1,350
Northwest Territories	1964	32	65.31	10,745
	1965	45	75.00	18,435
	1966	26	74.47	19,376
	1967	23	74.62	11,212
	1968	27	73.10	11,097
Canada	1964	51,671	69.48	20,206,543
	1965	53,103	73.86	23,365,493
	(3)1966	34,588	73.51	14,979,430
	(3)1967	34,590	73.57	15,026,378
	(3)1968	15,789	72.26	7,063,958

(1) Maximum allowance sharable by the federal government was increased from $65 to $75 a month as of December 1963.
(2) Most recipients transferred to provincial general assistance program.
(3) Excludes Quebec.

Subsection 5 - Fitness and Amateur Sport

The Fitness and Amateur Sport Act of 1961, administered by the Minister of National Health and Welfare, provides up to five million dollars a year to be spent on the encouragement, promotion, and development of active leisure pursuits for everyone in Canada. Although the federal, provincial, and municipal governments provide the funds and resources, the programs are carried out almost entirely by nongovernmental agencies. Under the Act, Canadian participation in active recreation and amateur sport can be promoted internationally, nationally, provincially, and locally through financial assistance, technical guidance, the provision of teaching materials, assistance to training, research, and the construction of facilities. The National Advisory Council of Fitness and Amateur Sport advises the Minister of National Health and Welfare in fitness and amateur sport matters; its 30 members are chosen for their interest and experience, with at least one member from each province.

The federal program has five elements. Grants to National Organizations, totalling more than a million dollars a year, go to some 50 national fitness and sports organizations to help to train coaches, to improve standards of instruction, to increase participation in sports, to aid the holding of national and regional competitions, and to assist Canadian athletic teams at international competitions. Grants for Athletic Events of nation-wide interest assist in the holding of such events as the 1967 Pan-American Games in Winnipeg, the 1967 Canadian Winter Games in Quebec City, the 1969 Canadian Summer Games in Halifax and Dartmouth, and the 1971 Second Canadian Winter Games. Grants for Training and Research are made for graduate study in fitness and amateur sport, for research fellowships, and for scholarships and bursaries for undergraduate study in Physical Education and Recreation.

Services of the Department of National Health and Welfare include the provision of technical advice, training material, and promotional aids. Visual aids for coaching, printed guides on particular sports and recreational activities, and technical information on the construction and use of facilities are provided. Typically Canadian sports and recreational activities have been fostered by "How To" kits that include an illustrated manual, a film to arouse interest in the subject, and films in which techniques are demonstrated; these kits and other films are available on loan from the Department's Fitness Film Library. Committees of the National Advisory Council meet frequently with the executives of sports organizations to discuss policy and a federal-provincial

committee of government officials advises on and co-ordinates governmental aspects of the program. The Department also co-ordinates work done by other federal agencies in fitness and amateur sport. Grants to the Provinces of $1 million a year are made to those that enter into cost-sharing agreements for provincial programs of fitness and amateur sport. The federal government meets 60 per cent of the cost of projects and the full cost of the undergraduate scholarships and bursaries. Applications for all grants at the provincial or local level are made in the first instance to the responsible provincial department.

The Municipal Role. The bulk of recreational activity occurs in the individual community, and municipal recreation departments co-ordinate community effort, provide continuity for voluntary organizations, and make long-range recreational plans. Thus, most ideas originate in the municipal recreation departments, where the needs of the communities are best known.

Subsection 6 - National Welfare Grants

The National Welfare Grants program was established in 1962 to help develop and strengthen welfare services in Canada through a general welfare and professional training grant and a welfare research grant. In the year ending March 31, 1969, $2,450,000 has been allocated to the program. The variety of provisions within the program, along with its associated consultative and technical services, allow it to operate as a flexible instrument in the development of welfare services and to give a major emphasis to experimental activities in the welfare field.

Under the program matching and non-matching grants are made available to provincial and municipal departments, national, provincial and local voluntary welfare agencies and organizations, schools of social work and research institutions for projects submitted and approved in accordance with the terms of annual Welfare Grants Rules, and to individuals for scholarships and fellowships provided for in the Rules. Consultative services are made available to assist with the initiation, implementation and evaluation of projects.

The National Welfare Grants program complements other federal and provincial programs restricted in their financial support to services directed to specific categories of people. In its experimental role assistance is given to research and demonstration projects that contribute to the growth of knowledge in the welfare field, that make possible the

collection of comprehensive and reliable data essential to program development, or that lead to the practical application of knowledge and experience to welfare services for the purpose of improving those services, encouraging their wider use and by building new qualities or innovations into them.

Under the general welfare and professional training grant, general welfare, bursary, training, and staff development grants are available to the provinces on a matching basis. General welfare grants provide funds for projects to improve welfare administration, to develop consultative and co-ordinating services, and to strengthen and extend public and voluntary welfare services in child welfare, aging, general assistance, and other welfare fields. Bursaries are provided for full-time graduate training in Canadian schools of social work. Training grants and staff development grants are available for personnel employed, or to be employed, in public and nongovernmental welfare agencies where such costs are not sharable under the Canada Assistance Plan.

Welfare scholarships are awarded for graduate study in Canadian schools of social work and fellowships for advanced study in Canadian and foreign universities. Teaching-and field-instruction grants assist with the development of new Canadian schools of social work, and with certain operating costs of established schools. These provisions are administered directly by the Federal Government on a non-matching basis.

Grants are made to national voluntary welfare agencies to assist with projects not eligible for support under other sections of the program. While a particular emphasis has been given to staff development activities a wide range of projects can be supported under this provision.

Under the welfare research component non-matching grants are awarded for a variety of research projects undertaken by public and voluntary welfare and related agencies, universities and schools of social work, and research institutions.

Expenditures under the program for the year ended March 31, 1968, appear in Table 30.

Effective April 1, 1967, a mental retardation grant was established for a five-year period. A portion of this grant is being administered in conjunction with the National Welfare Grants program. With the need to emphasize prevention in this field, support is being given to research and demonstration projects designed to expand knowledge and to demonstrate new ways in which knowledge can be applied to the provision of services. In the year ending March 31, 1968 $133,407 was expended for projects in this field.

TABLE 30 - FEDERAL EXPENDITURES UNDER THE NATIONAL WELFARE GRANTS PROGRAM, BY PROVISION AND PROVINCE, YEAR ENDED MARCH 31, 1968.

Province	Welfare service plans(1)	Welfare demonstration projects(2)	Welfare research	Teaching and field instruction(3)	Welfare scholarships(4)	Welfare fellowships(4)	National voluntary welfare agency projects	Totals
	$	$	$	$	$	$	$	$
Newfoundland	3,689	-	-	-	-	-	-	3,689
Prince Edward Island	1,325	19,527	-	-	2,496	-	-	23,348
Nova Scotia	2,850	49,226	9,437	46,849	6,290	-	-	114,652
New Brunswick	12,609	-	4,170	-	-	-	-	16,779
Quebec	-	-	34,223	-	6,000	7,150	-	47,373
Ontario	239,897	77,018	38,651	205,564	49,879	35,880	-	646,889
[illegible]	5,225	44,978	[illegible]	[illegible]	1,690	-	-	183,611
Saskatchewan	20,850	75,912	3,050	-	7,630	-	-	107,442
[illegible]	5,000	[illegible]	[illegible]	35,000	2,030	-	-	56,220
[illegible]	[illegible]	82,904	76,023	99,788	5,575	12,959	-	282,589
Yukon Territory	20,440	-	-	-	-	-	-	20,440
Northwest Territories	38,818	-	-	-	-	-	-	38,818
Not classified(5)	-	-	107,767	-	-	-	237,114	344,881
[illegible]	355,953	354,945	328,314	472,826	81,590	55,989	237,114	1,886,731

(1) Require a matching contribution of provincial and/or municipal funds.
(2) Financed out of federal allocations to the provinces but do not require matching.
(3) By location of school.
(4) By home address of recipients.
(5) Amounts payable to national voluntary welfare agencies for projects and for welfare research.

Subsection 7 - Vocational Rehabilitation

The federal-provincial vocational rehabilitation program, which began in 1952, was consolidated and extended under the Vocational Rehabilitation of Disabled Persons Act, 1961. Federal-provincial agreements under this Act provide for equal sharing of costs between the Federal Government and the provinces. These costs include co-ordination and provision of services to disabled or other vocationally disadvantaged individuals, training of rehabilitative personnel, and research and publicity. Approved services, supplied by a provincial government or purchased from voluntary agencies by a provincial government, include medical, social, and vocational assessment, intensive counselling, restorative services, the provision of prostheses, vocational training or educational upgrading, rehabilitation allowances, work conditions, and provision of tools, books and other equipment. Employment counselling and placement is provided through Canada Manpower Centres of the Department of Manpower and Immigration.

In each participating province a provincial co-ordinator or director of rehabilitation is responsible for the co-ordination and administration of services to disabled or vocationally disadvantaged persons. The federal aspects of the program are administered by the Department of Manpower and Immigration's Manpower Utilization Branch in co-operation with the Department's five regional offices. The Manpower Utilization Branch, through its Section on Older Workers, also has the function of encouraging a more favourable employment climate for older workers through a continuing educational program, encouragement of research, maintenance of liaison with management, labour, and voluntary agencies, the assembly and dissemination of informational material, and supportive services to Canada Manpower Centres through the Department's five regional offices.

Among other agencies contributing to vocational rehabilitation are the Workmen's Compensation Boards in all provinces, which provide for the rehabilitation of injured workmen.

As approved by provincial health departments, the Prosthetics Services established for veterans are being extended to the general public through 12 prosthetic centres administered by the Department of National Health and Welfare.

In the year ended March 31, 1968, federal expenditures under the program totalled $2,157,894. Reports were received on 2,995 disabled or vocationally disadvantaged persons

rehabilitated during the year. Before rehabilitation the cost of supporting these people and their dependents was an estimated annual amount of $3,200,000. After rehabilitation their estimated annual earnings were $8,600,000.

Subsection 8 - National Council of Welfare

Co-ordination in welfare matters between different levels of government and between government and voluntary authorities is facilitated by the National Council of Welfare, an advisory body to the Minister of National Health and Welfare. The Council consists of the Deputy Minister of National Welfare as the chairman, the provincial deputy ministers of welfare, and ten other persons appointed for three-year terms by the Governor-in-Council.

Section 3 - Provincial Welfare Programs

Major welfare programs governed by provincial legislation are social assistance (including assistance to needy mothers with dependent children), services for the aged, and child welfare services. Also, the Province of Quebec has established and is operating the Quebec Pension Plan, which is comparable to the Canada Pension Plan. Both Plans commenced in January 1966 and are closely co-ordinated (see p. 51). Quebec has also enacted in 1967 its own family allowances program (see p.104). In most provinces, responsibility for a number of the programs is shared by the provinces and their municipalities. Provincial administration is carried out through the department of public welfare in each province; several departments have established regional offices to facilitate administration and to provide consultative services to the municipalities.

The provincial departments of public welfare are placing increasing emphasis on standards of administration and on rehabilitative and preventive services for social assistance recipients. Costs of these services are now shared with the municipalities.

Public services are supplemented by those of voluntary agencies whose interests include the welfare of families and children and of groups with special needs, such as the aged, recent immigrants, youth groups, and released prisoners. Welfare councils and social planning councils contribute to the planning and co-ordinating of local welfare services. Local voluntary agencies and institutions may receive public grants, depending on the nature and standard of their services, although their main support is usually from united funds or community chests, or from sponsoring organizations.

Subsection 1 - Social Assistance

All provinces make legislative provision for assistance to persons in need and their dependents including mothers with dependent children and those whose benefits under other programs are not sufficient to meet their needs. With the exception of Quebec, all provinces have now incorporated provisions for allowances to needy mothers with dependent children in a broadened program of provincial allowances to several categories of persons with long-term need or in a general program under which the only eligibility requirement is need irrespective of the cause of need.

Allowances are now generally determined on the basis of a needs test under which the allowance granted is the budget deficit or the difference between the amount required to meet the applicant's need as determined according to a schedule of rates covering the various budget items of basic need (food, clothing, personal requirements, shelter, fuel, and utilities) and any income available to him to meet that need. All provinces also provide allowances for items of special need; for example, special diets on medical recommendation, special clothing, and expenses incidental to education or obtaining employment. Assistance may also take the form of maintenance in a home for special care or welfare services (see section on Canada Assistance Plan).

The provincial departments of public welfare have regulatory and supervisory powers over municipal administration of social assistance and require certain standards as a condition of provincial aid. Length of residence is not a condition of aid in any province, but in the four provinces where municipal residence is a factor, the residence of the applicant determines the financially responsible authority. Assistance to persons without municipal residence or persons living in unorganized territory is the responsibility of the provincial authority. Under the terms of the Canada Assistance Plan, all provinces have agreed that residence shall not be a condition of assistance for applicants who move from one province to another.

Social assistance is administered by the province or by the municipalities with substantial financial support from the province which in turn is reimbursed by the federal government under the Canada Assistance Plan for 50 per cent of the provincial and municipal assistance given, and for 50 per cent of the extension or improvements of welfare services. The formula for provincial-municipal sharing of costs is determined by the province, and varying arrangements are made for the administration of assistance.

As authorized under the terms of the Canada Assistance Plan, a number of provinces have elected to assist needy persons of 65 years of age or over, the needy disabled, and the needy blind under their general assistance programs rather than under the federal-provincial programs for the particular categories of needy persons (see section on Canada Assistance Plan). By mid-1968 five provinces -- Newfoundland, Prince Edward Island, Ontario, Saskatchewan, and Alberta -- had discontinued receipt of applications under the old age assistance and disabled persons allowances programs. Three of these provinces -- Ontario, Saskatchewan and Alberta -- had also discontinued applications under the blind persons allowances program.

In Newfoundland all assistance is administered provincially. In Prince Edward Island, mothers' allowances were amalgamated with other forms of assistance in a general program under the Welfare Assistance Act, 1966. Under this Act the province assumed responsibility for the costs of assistance and services to all needy persons with no requirement for a financial contribution from the municipalities. Assistance is administered by the province, two municipalities and two welfare bureaus.

The Social Welfare Act in New Brunswick, which became effective January 1, 1967, transferred the administration of assistance from the municipalities to the province. No categories of needy persons are specified; allowances are payable to needy mothers on the same basis as to other needy persons. In Nova Scotia, the province administers aid under the Social Assistance Act to needy mothers and foster mothers, aid to disabled persons who do not qualify for assistance under the federal-provincial disabled persons allowances program, and supplemental allowances to recipients of old age assistance, blind persons allowances and disabled persons. The municipalities administer assistance to other needy persons and are reimbursed by the province according to a formula for at least 75 per cent of the costs of assistance, services, and administration.

In Quebec, the province administers aid to needy mothers under the Needy Mothers Assistance Act and aid under the Quebec Public Charities Act to persons with long-term need: disabled persons whose disability is likely to last more than 12 months, needy widows of 60 years of age or more, recipients of federal or provincial categorical payments or allowances who require supplemental aid. The municipalities administer short-term aid, but the cost of such aid is borne by the province.

In Ontario, the Family Benefits Act, 1966, effective April 1, 1967, integrated provincial allowances to persons with long-term need formerly aided under a number of separate Acts. The Act covers allowances to needy mothers with dependent children, dependent fathers, disabled or blind persons, persons 65 years of age or over who are not receiving an old age security pension, needy widows, and certain other categories of women 60 years of age or over. Municipalities administer aid under the General Welfare Assistance Act to other needy persons and are reimbursed by the province for 80 per cent of their expenditures for aid and for 90 per cent of expenditures for aid to persons in excess of 5 per cent of the population in the municipality. The province reimburses counties and municipalities for 50 per cent of the cost of special assistance and of the cost of administration of welfare services beyond a specified base period.

In Manitoba, the province administers aid under the Social Allowances Act to needy mothers with dependent children, to mentally or physically incapacitated persons whose disability is likely to last for more than 90 days and to persons unable to support themselves or their dependents because of their age. Financial aid and services to other needy persons is the responsibility of the municipalities which are reimbursed through the Department of Welfare for 40 per cent of the costs of assistance, or at a higher rate if their costs exceed a specified amount. Since April 1, 1967, the province has also reimbursed municipalities for 50 per cent of the costs of administration of welfare services in excess of costs for the base year 1964.

In Saskatchewan, the Saskatchewan Assistance Act, 1966 eliminated categorical allowances; all aid is now provided under a single comprehensive program in which need is the only criterion of eligibility. The program of assistance and services under the Act is administered by local units, that is, by a municipality or combination of municipalities, or by provincial units, that is, by regional offices of the Department of Welfare. Most municipalities have not elected to administer the program and in these areas and in unorganized territory assistance and services are administered by provincial units. The province bears approximately 95 per cent of the costs of assistance and services granted in the municipalitites.

In Alberta, the provincial Department of Public Welfare administers allowances under the Public Welfare Act to needy mothers with dependent children, to persons who are mentally or physically handicapped for a period likely to last for more than 90 days, and to persons who because of their age are not able to be self-supporting. The Department maintains two hostels and one welfare centre to care for unemployable

single homeless men without municipal residence. Aid to other needy persons is administered by the municipalities which are reimbursed by the province for 80 per cent of the assistance given. Also, under the Preventive Social Services Act, 1966, designed to encourage municipalities to sponsor programs to prevent dependency and family breakdown, the province reimburses a municipality for 80 per cent of the costs of administration of material aid given needy persons under the Public Welfare Act, and for 80 per cent of the municipal expenses in connection with the establishment, operation and administration of certain preventive social service programs.

In British Columbia, the Department of Social Welfare administers supplemental allowances to needy recipients of Old Age Security pensions, blind and disabled persons' allowances. Aid to other needy persons is administered under a comprehensive general program by the municipalities, or by the province in areas without municipal organization. Municipalities are reimbursed by the province on a pooled basis for 90 per cent of the total cost of social assistance. Also, the province shares equally with the municipalities expenditures on salaries of social workers; a municipality with fewer than 15,000 persons may arrange to have the Department undertake social work within the municipality and reimburse it at the rate of 60 cents per capita per year.

Subsection 2 - Living Accommodation for Elderly Persons

In all provinces, homes for the aged and infirm are provided under provincial, municipal, or voluntary auspices. Voluntary homes generally are provincially inspected in accordance with prescribed standards and in some provinces must be licensed. The provinces contribute to the maintenance of needy persons in homes for the aged, either through general assistance or through statutes that relate particularly to these homes. Also, 50 per cent of the payments on behalf of assistance cases in homes for the aged and infirm (homes for special care) are met by the federal government (see p. 76).

All provinces in varying degrees make capital grants toward the construction of homes, and in some provinces capital grants are also available to municipalities, charitable organizations, or non-profit corporations for the construction of low-rental housing.

Newfoundland maintains a home for the aged and infirm at St. John's and pays part or all of the cost of maintaining needy old people in homes for the aged and boarding homes.

Provision is made for grants to organizations constructing homes for the aged. The Senior Citizens (Housing) Act, 1960 provides for the construction of hostels or housing for the elderly by non-profit corporations. The province guarantees the cost of operating such projects. Three institutions operated by the Department of Welfare in Prince Edward Island and one operated by a charitable organization provide care for the aged and infirm. In Nova Scotia, the aged are cared for in municipal or county homes, in homes operated by religious or private organizations, and in private boarding homes. The province reimburses the municipalities for two-thirds of their expenditures for the maintenance of needy persons in municipal homes, subject to compliance with specified standards of care and accommodation. Homes for the aged receiving aid from the provincial government are subject to provincial inspection. In New Brunswick provincial grants may be made under the Senior Citizens Housing Act to assist non-profit housing corporations in constructing and equipping low-rental housing units for senior citizens. Similarly, grants to construct homes for the aged and nursing homes are available under the Auxiliary Homes Act. Homes for the aged are operated under public, charitable, and private auspices. Voluntary and proprietary homes are subject to provincial licensing and inspection and must meet standards contained in regulations under the Health Act. Under the Social Welfare Act, 1966, the province contributes to the maintenance of needy persons in licensed nursing homes and homes for the aged.

Institutional care for indigent old people in Quebec is provided through charitable institutions under the Public Charities Act. The Aged Couples Homes Act authorizes the province to erect and maintain homes for aged couples, or to make agreements (including the provision of grants) for their erection, upkeep and administration with persons, societies and corporations, public or private. Standards established for homes for the aged are in accord with the regulations under the Public Health Act.

Under the Homes for the Aged and Rest Homes Act in Ontario municipalities must provide institutional or special home care (private family living or foster home care) for the aged; they may also establish rest homes for the care of handicapped persons who cannot be properly cared for at home, in existing homes for the aged, hospitals, or other institutions The province contributes 50 per cent of the costs of construction of approved homes and 70 per cent of their operating and maintenance costs. It also pays 70 per cent of the costs of maintenance for approved special home care up to a maximum of $90 per month. Homes for the aged under voluntary auspices are approved, inspected, and assisted under the Charitable Institutions Act. This Act provides for construction grants

up to $5,000 per bed and for maintenance grants of 80 per cent of the amount spent by the organization up to $8 per day for each resident. The Nursing Homes Act, 1966 established mandatory provincial licensing of nursing homes by the Department of Health for the first time. The Elderly Persons' Housing Aid Act provides for grants to non-profit housing corporations building low-rental housing for elderly persons.

Institutions and boarding homes for the aged and infirm in Manitoba are supervised and licensed by the Department of Health under public health legislation. The province makes construction grants equalling one-third of the costs of constructing or of acquiring and renovating housing accommodation and homes for the aged to municipalities and charitable organizations under The Elderly and Infirm Persons' Housing Act. Grants may not exceed $1,700 for one-person housing units, $2,150 for two-person housing units, $2,000 per bed for new homes for the aged, and $1,000 per bed for homes that have been renovated. Under the Social Allowances Act the province bears the entire cost of allowances to those who, because of age, physical or mental ill health, or physical or mental incapacity, require care for more than 90 days by another person or in an institution or home for the aged and infirm.

In Saskatchewan, aged and infirm persons are cared for in five provincial geriatric centres, three under the jurisdiction of the Department of Welfare, one under that of the Department of Public Health, and one under that of the Anti-tuberculosis League and in municipal, voluntary, and proprietary homes for the aged. The latter are inspected and licensed under the Housing and Special-care Homes Act. This Act also empowers the province and municipalities to subscribe to the capital stock of non-profit housing corporations building low-rental accommodation for older persons; the province may also make loans to municipalities to assist them in subscribing. Also, the province may guarantee the costs of operation of hostel-type accommodation with common dining and sitting rooms for aged persons. Capital grants amounting to 20 per cent of construction costs and annual maintenance grants of $40 for each self-contained housing unit and of $60 for each bed in a special-care home (that is, a nursing home, supervisory care home, or sheltered care home) may be made to municipalities, churches, or charitable organizations sponsoring approved homes or housing projects. Costs of maintaining needy persons in homes for the aged are shared by the province and the municipalities under the Saskatchewan Assistance Act.

Under what are termed "master agreements", Alberta bears the cost of constructing and equipping homes for the aged and housing units on municipal land. Projects are operated by

provincially incorporated foundations which include municipal councillors in their membership; net costs of operation are borne by the municipalities. Aside from contract nursing homes, which come under specific legislation, and certain nursing homes under the supervision of the Department of Health, the Welfare Homes and Institutions Branch of the Department of Public Welfare is responsible for the licensing of and the maintaining of standards in homes for the aged and infirm.

A home for elderly homeless men is operated by the Department of Social Welfare in British Columbia. Boarding homes or institutional facilities for the care of the aged and infirm may be provided under municipal, non-profit or proprietary auspices. The province licenses and supervises homes for the aged and boarding homes and, where necessary, shares with the municipalities on a 90-10 basis the cost of maintaining needy residents. Under the Elderly Citizens' Housing Aid Act, the province makes grants amounting to one-third of construction costs to municipalities, regional districts and non-profit corporations, including religious and service organizations, engaged in building homes or low-rental housing units for elderly citizens.

Subsection 3 - Recreational Centres for Elderly Persons

Ontario gave impetus to the provision of recreation centres for older people through its Elderly Persons' Social and Recreational Centres Act, 1961-62. In 1966 the Elderly Persons Centres Act was passed. When proclaimed, it will replace the earlier legislation. The new Act continues the arrangement for a provincial grant of up to 30 per cent of the cost of constructing or buying a building for use as a recreational centre if the municipality contributes 20 per cent. In addition, provision is made for maintenance grants and special grants for services, facilities, and research.

Subsection 4 - Child Welfare Services

Child welfare services, which include child protection and care, services for unmarried parents, and adoption services, are provided in all provinces under provincial legislation. The program may be administered by the provincial authority or the responsibility may be delegated to local children's aid societies (voluntary agencies with boards of directors, operating under charter and under the general supervision of provincial departments). In Newfoundland, Prince Edward Island, New Brunswick, Saskatchewan,

and in Alberta, child welfare services are administered by the province; in Quebec they are administered by recognized voluntary agencies and institutions, religious and secular; in Ontario, a network of local children's aid societies is responsible for the services; in Nova Scotia, Manitoba and British Columbia, services are administered by local children's aid societies in the heavily populated areas and by the province elsewhere.

Children's aid societies and the recognized agencies in Quebec receive substantial provincial grants and sometimes municipal grants and in many areas they also receive support from private subscriptions or from community chests or united funds. The cost of certain services and maintenance for children in care of a voluntary or public agency, formerly borne by the province or partly by the municipality of residence and partly by the province, are sharable with the Federal Government under the Canada Assistance Plan (see p. 76).

The child welfare agencies, provincial or voluntary, have the authority to investigate cases of alleged neglect and, if necessary, to apprehend a child and to bring the case before a judge upon whom rests the responsibility of deciding whether in fact the child is neglected. When neglect is proved, the court may direct that the child be returned to his parent or parents, under supervision, or be made a ward of the province or a children's aid society. Services are provided as appropriate and include services to children in their own homes, care in foster boarding homes or adoption homes, or, for children who need it, in selected institutions. Children placed for adoption may be wards or they may be placed on the written consent of the parent. Adoptions, including those arranged privately, number about 16,000 annually.

Child welfare agencies make use of the small selective institution for placement of children who are forced to be away from their own homes for a short period or who may need preparation for placement in foster homes, and emphasis is increasingly being placed on group-living homes. The development of small, highly specialized institutions, which function as treatment centres for emotionally disturbed children, is of particular significance. Institutions for children are governed by provincial child welfare legislation and by provincial or municipal public health regulations; they are generally subject to inspection and in some provinces to licensing. Sources of income may include private subscriptions, provincial grants, and maintenance payments on behalf of children in care, payable by the parents, the placing agency, or the responsible municipal or provincial department.

Services to unmarried parents include casework services to the mother and possibly to the father, legal assistance in obtaining support for the child from the father, and foster-home care or adoption services for the child. Support for unmarried mothers may be obtained under general assistance programs. In many centres, homes for unmarried mothers are operated under private or religious auspices.

Day nurseries for the children of working mothers are established only in the larger centres. These are chiefly under voluntary auspices, except in Ontario, where there are also municipally sponsored day nurseries operated with the aid of provincial grants.

Subsection 5 - Newfoundland's Schooling Allowances Program

The Province of Newfoundland introduced its Parents Supplement (Schooling Allowances) Program in 1966. Under this scheme, an annual benefit of $15 is paid in semi-annual instalments for each eligible child who is registered at and attending a school other than a trade school or university. There is no age limit specified in the legislation but the allowance terminates when the child leaves school.

Subsection 6 - The Province of Quebec's Family Allowances Program

The province of Quebec introduced its own family allowances program under legislation enacted in 1967. Under this plan, the following allowances are paid at the end of each six-month period to persons satisfying the relationship and residence requirements in respect of children under 16 years of age: $15 for one child, $32.50 for two children, $52.50 for three children, $77.50 for four, $107.50 for five, $142.50 for six, and an extra $35 for each child after the sixth. These allowances are increased by $5 for each child between the ages of 12 and 16 years. To qualify for the allowances, children must be attending school regularly from the time when they are first required to do so, unless prevented by physical or mental infirmity. These allowances supplement those paid under the federal scheme.

Section 4 - Emergency Welfare Services

The Emergency Welfare Services Division is intended to develop community capability to provide, in the event of a national emergency, essential welfare services that the established welfare agencies would be unable to provide. In 1959 an Order in Council established five emergency welfare services: emergency clothing, emergency feeding, emergency lodging, registration and inquiry, and personal services. The legislation also gives the Division responsibility for the continuation of welfare departments in support of rehabilitation and recovery. To these ends, policy has been defined, systems designed, and, at all levels of government, welfare resources planned.

In peacetime trained specialists within the federal, provincial, and municipal departments of welfare, organized nationally, are responsible for developing an emergency welfare capability. The program is an integral and significant part of the Canada Survival Plan and is co-ordinated with the programs of other government agencies, and, for co-ordination of mutual support activities, with the Welfare Administration of the U.S. Department of Health, Education and Welfare.

Training of leaders in the art of organizing large numbers of volunteers for emergency welfare operations is going on. Special printed forms and equipment for survival, not regularly available through commercial sources, have been produced and are located strategically across Canada. A public education program is maintained.

Section 5 - International Welfare

Canada is actively involved in the social welfare and social development activities of the United Nations and its specialized agencies and of various international voluntary organizations. At the United Nations Canada is represented on the Commission for Social Development, is a member of the governing bodies of the United Nations Children's Fund (UNICEF) and the International Labour Organization and actively participates in the work of a number of related organizations such as the Society for International Development,the International Council on Social Welfare, and the International Social Security Association. The Department of National Health and Welfare provides representatives to such organizations, participates in international studies, and contributes to the development of Canadian policy in this sector.

Under the program of the Canadian International Development Agency, Canada supports a number of social welfare projects in developing regions as well as providing social work and social welfare training for foreign students recommended by their governments. The necessary technical services to the bilateral and multilateral aid programs in this sector are supplied by the Department of National Health and Welfare, which also works closely with several Canadian voluntary organizations engaged in social development.

PART III - HEALTH AND SOCIAL WELFARE EXPENDITURES

Section 1 - Government Expenditures on Health and Social Welfare

In the seven years ended March 31, from 1962 to 1968, expenditures by all levels of government on health and social welfare rose from $3,689,200,000 to a record high estimated at $6,553,100,000, an increase of over 75 per cent. If these figures are adjusted to take account of the growth in population, the increase in per capita expenditures - from $201 to $321 - is about 60 per cent. Government expenditures may also be measured in relation to major economic indicators; on this basis, annual government expenditures on health and social welfare over the 1962-68 period have remained relatively stable, fluctuating between 11.8 and 13.9 per cent of net national income and between 8.8 and 10.4 per cent of gross national product; for the year ended March 31, 1967, the values are estimated to be 13.9 and 10.4 per cent, respectively.

The federal share of health and social welfare expenditures fell from 69.9 per cent in 1961-62 to 60.8 per cent in 1967-68, the provincial share rose from 27.2 per cent to 37.0 per cent, and municipal outlays declined from 2.9 per cent to 2.2 per cent.

Compared with the previous year, 1966-67, health and social welfare expenditures by all levels of government increased by $1,177,500,000 or 22 per cent. In the federal field the increase amounted to 23 per cent and showed the greatest gain. The main items causing this rise included higher disbursements under the Old Age Security program with the lowering of the eligible age for recipients, new expenditures under the Guaranteed Income Supplement program which commenced effective January 1, 1967, the greater expenditure incurred by the introduction of the Canada Assistance Plan which is wider in scope than the categorical programs it is intended to replace, higher expenditures under the Unemployment Insurance Act, greater outlays for health and welfare on behalf of the Indian and Eskimo populations, expenditures which continue to rise under the Hospital Insurance and Diagnostic Services Act and contributions to the provinces under the Health and Hospital Construction Grants and the new Health Resources Fund Act. The provincial expenditures rose by 21 per cent while those of the municipal governments increased by 8 per cent.

The relative federal declines compared to provincial gains in each of the three years up to 1966-67 were caused to a substantial degree by increasing hospital expenditures by the provincial governments augmented, in the last two years,

by the effect of the "opting out" arrangements made available to the provinces. Under the Established Programs (Interim Arrangements) Act, a province may "opt out" of federal-provincial programs, operate and finance these as provincial schemes, and receive a tax abatement and an equalization payment from the federal government in lieu of a direct federal contribution to the program. The opting-out arrangements have the effect of showing an increase in provincial government expenditure while the federal fiscal payment is not treated asaan expenditure but as a transfer payment. Thus, provincial expenditures include gross outlays by the Province of Quebec, the only province at this date to make use of these arrangements, whereas the federal expenditures on health and social welfare do not include the large sums paid or transferred to that province under the Established Programs (Interim Arrangements) Act and other agreements. However, as mentioned above, in 1967-68 estimated federal government expenditures on social security showed the greatest gain at all levels of government over the previous year.

The proportion of government expenditures on health and social welfare taken up by health programs continues to grow; in 1961-62 such programs accounted for $1,126,000,000 or 30 per cent and in 1967-68 for $2,454,500,000 or 37 per cent.

An outline of the principal components for 1967-68 shows the magnitude of the major programs and services - family allowances payments amounted to $559,000,000, old age security payments to $1,153,000,000 plus another $235,000,000 under the guaranteed income supplement program, unemployment insurance benefits to $389,000,000, and veterans' pensions and allowances to $206,000,000 and $105,000,000, respectively. These income-maintenance programs were entirely the responsibility of the Federal Government. In addition, payments under the youth allowances program, which commenced in September 1964, amounted to $49,000,000 in 1967-68, excluding the Province of Quebec. That province had instituted a program of schooling allowances three years prior to the introduction of the federal program and this fact necessitated a special arrangement whereby Quebec continued its program but with appropriate fiscal arrangements with the Federal Government.

In 1967-68 the Province of Quebec inaugurated its own family allowance program in respect of children under 16 years of age, which is in addition to the federal program operating in that province. The legislation became effective in April 1967 and payments are made in June and December at each year (see p. 104).

Federal-provincial income-maintenance programs required expenditures of $36,000,000 for old age assistance, $5,000,000 for blindness allowances, $31,000,000 for disabled persons allowances, and $41,000,000 for unemployment assistance, the latter including some municipal expenditures. Effective April 1, 1965, Quebec withdrew from these federal-provincial programs under the Established Programs (Interim Arrangements) Act, which entitled that province to a tax abatement as an equalization payment. Expenditures under the Canada Assistance Plan were estimated at $690,000,000 in 1967-68. This program was designed to replace the Unemployment Assistance Act, although certain costs not covered by the Plan may continue to be paid under that Act. The Plan may also replace the old age assistance, blind persons allowance, and disabled persons allowance programs at the option of each province (see p. 76). It is estimated that Workmen's Compensation Boards spent $175,000,000 on cash benefits for pensions and compensation. Welfare services for Indians and for veterans and the National Employment Service accounted for approximately $93,000,000 at the federal level.

In the field of health, federal grants to the provinces under the Hospital Insurance and Diagnostic Services Act totalled almost $470,000,000 and grants for hospital construction and general health grants to the provinces and municipalities amounted to $46,000,000. The Federal Government spent $40,000,000 on its Indian and northern health services and $63,000,000 on hospital and treatment services for veterans. Provincial expenditures on hospital care are estimated to have totalled over $1,300,000,000, and $300,000,000 was spent on other health services. Workmen's Compensation Boards paid an estimated $75,000,000 for medical aid and hospitalization, and municipal governments spent $75,000,000 on health.

Section 2 - Expenditures on Personal Health Care

Expenditures on personal health care comprise expenditures of hospitals, earnings of physicians and dentists for professional services to their patients,the value of prescription sales through retail pharmacies, and an estimate of the amounts that private nurses, chiropractors, osteopaths, and optometrists receive for their professional services; they exclude expenditures on public health, capital costs (buildings and interest) and administration costs of public-health programs and of insurance plans.

Table 33 shows the components for each year from 1956 to 1966. Canadians spent a total of $2,816 million on personal health care in 1966, almost three times as much as ten years before.

TABLE 31 - TOTAL, PER CAPITA, AND PERCENTAGE DISTRIBUTION OF GOVERNMENT EXPENDITURES ON HEALTH AND SOCIAL WELFARE, BY LEVEL OF GOVERNMENT, YEARS ENDED MARCH 31, 1962-68

Year ended March 31	Federal	Provincial	Municipal	Total
	Total Expenditures			
	$'000,000	$'000,000	$'000,000	$'000,000
1962	2,577.1	1,004.3	107.8	3,689.2
1963	2,683.5	1,097.7	117.3	3,898.5
1964	2,801.0	1,166.8	101.2	4,069.1
1965	2,969.7	1,376.1	108.2	4,454.0
1966	2,883.5	1,708.2(1)	120.0(1)	4,711.7(1)
1967	3,243.1	2,002.5(1)	130.0(1)	5,375.6(1)
1968(1)	3,986.5	2,426.6	140.0	6,553.1
	Per Capita Expenditures			
	$	$	$	$
1962	137.94	53.75	5.77	197.46
1963	141.14	57.74	6.17	205.05
1964	144.67	60.27	5.23	210.17
1965	150.63	69.80	5.49	225.92
1966	143.04	84.75(1)	5.95(1)	233.74(1)
1967	157.83	97.45(1)	6.33(1)	261.61(1)
1968	190.90	116.20	6.70	313.80
	Percentage Distribution			
1962	69.9	27.2	2.9	100.0
1963	68.8	28.2	3.0	100.0
1964	68.8	28.7	2.5	100.0
1965	66.7	30.9	2.4	100.0
1966	61.2	36.3(1)	2.5(1)	100.0
1967	60.3	37.3(1)	2.4(1)	100.0
1968(1)	60.9	37.0	2.1	100.0

(1) Estimated.

TABLE 32 - EXPENDITURES OF ALL LEVELS OF GOVERNMENT ON HEALTH AND SOCIAL WELFARE IN RELATION TO NET NATIONAL INCOME AND GROSS NATIONAL PRODUCT, YEARS ENDED MARCH 31, 1962-68

Year ended March 31	Government expenditures on health and social welfare		
	Amount	Per cent of net national income	Per cent of gross national product
	($ millions)		
1962	3,689.2	12.8	9.7
1963	3,898.5	12.6	9.5
1964	4,069.1	12.2	9.2
1965	4,454.0	12.3	9.2
1966	4,711.7(1)	11.8	8.8
1967	5,375.6(1)	12.2	9.1
1968	6,553.1(1)	13.9	10.4

(1) Estimated.

TABLE 33 - EXPENDITURES ON PERSONAL HEALTH CARE, CANADA, 1956-1966

Year	Hospital services					Physicians' services	Dentists' services	Prescribed drugs(3)	Other personal health services(4)	Total
	Active treatment hospitals	Psychiatric institutions	Tuberculosis sanatoria(1)	Government of Canada(2)	All hospitals					
	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000
1956	380.8	77.6	30.6	40.8	529.8	240.1	81.5	71.8	65.0	988.2
1957	422.9	87.5	31.0	45.3	586.7	271.8	87.3	84.5	70.0	1,100.3
1958	462.3	99.0	30.4	48.4	640.1	301.3	98.1	90.3	85.0	1,214.8
1959	542.6	111.6	29.6	50.3	734.1	325.7	99.0r	106.5	95.0	1,360.3r
1960	625.2	120.2	30.1	53.9	829.4	355.0	109.6	109.6	105.0	1,508.6
1961	713.4	134.9	29.9	63.9	942.1	388.3	116.7r	122.8r	115.0	1,684.9r
1962	802.9	144.4	29.1	70.3	1,046.7	406.1	121.7r	125.8r	125.0	1,824.7r
1963	900.1	163.0	28.1	73.8	1,165.0	453.4	136.9r	140.8r	139.0r	2,035.1r
1964	1,003.7	182.1	25.9	76.8	1,288.5	495.7	147.8r	154.4r	153.0r	2,239.4r
1965	1,125.9	210.7	25.9	79.8	1,442.3	545.1	160.1r	169.7r	169.0r	2,486.2r
1966	1,300.5	241.8	26.2	82.1	1,650.6	605.2	176.4	190.3	193.0	2,815.5

(1) Excludes hospitals of the Department of National Health and Welfare.
(2) Excludes hospitals of the Department of National Defence for 1956-1960.
(3) Sold by retail drugstores only.
(4) Estimates of expenditures for services of private nurses, chiropractors, osteopaths and optometrists; excludes hospital employees.

r Revised since previous publication.

Expressed as a proportion of the gross national product, personal health care expenditures rose from 3.2 per cent in 1956 to 4.8 per cent in 1966. Expenditure per person over the same period changed from $61.45 in 1956 to $140.64 in 1966. Expressed in constant dollars, according to the consumers price index, the expenditure per person increased by 65 per cent over the same period, or by an average of 5.2 per cent per year.

Section 3 - Earnings of Privately Practising Physicians in Canada

The average gross professional earnings of fee-practising physicians in 1966 were $35,223, as shown in Table 34. This figure was 7.4 per cent higher than in 1965 and 54 per cent above the 1959 figure. The highest average gross earnings in 1966 were reported in Saskatchewan, at $40,150. In Ontario, Alberta, and British Columbia they were above the national average. Average gross incomes in the remaining provinces ranged from $33,688 in Manitoba to $26,284 in Prince Edward Island.

Generally, through the eight-year period 1959-66, average gross earnings have been at a higher level in Newfoundland, Ontario, and the western provinces while grouped at a somewhat lower level in Quebec and the maritime provinces.

The net returns to physicians, after deduction of the expenses of professional fee practice, reveal similar geographic patterns, as seen in Table 27. Net earnings for Canada as a whole averaged $23,262 in 1966. This figure was 5.4 per cent higher than in 1965 and 59 per cent above the 1959 figure. The highest provincial average net income from professional practice was reported by Ontario physicians at $25,456 followed by Alberta physicians at $24,356. The lowest provincial average net income, $18,910, was reported for Prince Edward Island.

Section 4 - Number of Physicians in Canada

There were about 22,816 physicians in Canada (exclusive of those in the Yukon and Northwest Territories) in August 1967, or one physician for every 857 persons of the population. Table 28 gives the provincial distribution and population/physicians ratios as calculated for 1967, and shows also the historical trends for Canada since 1901. British Columbia has the most favourable provincial ratio of physicians to population, followed by Ontario and Manitoba.

TABLE 34 - AVERAGE GROSS PROFESSIONAL EARNINGS(1) OF ACTIVE FEE-PRACTICE PHYSICIANS, CANADA BY PROVINCE, 1959 TO 1966

Province	1959	1960	1961	1962	1963	1964	1965	1966
	$	$	$	$	$	$	$	$
Newfoundland(2)	24,669	28,583	27,184	24,809	27,903	30,630	31,620	33,688
Prince Edward Island	18,854	20,177	20,001	19,676	23,413	23,157	25,596	26,284
Nova Scotia	21,341	22,802	23,242	23,302	23,455	25,739	27,486	29,960
New Brunswick	18,918	22,523	24,220	23,978	26,376	27,802	29,622	30,271
Quebec	18,721	19,656	22,118	23,418	25,748	26,813	29,010	30,901
Ontario	24,153	25,534	27,206	27,779	30,641	33,201	35,752	38,254
Manitoba(3)	27,567	25,767	29,072	29,003	28,769	29,103	32,037	33,589
Saskatchewan	23,699	27,102	27,103	23,238	35,657	36,484	37,474	40,150
Alberta	25,254	28,032	29,221	31,187	30,912	32,690	35,397	37,871
British Columbia	26,628	28,066	27,867	27,498	27,670	30,510	31,675	36,063
Yukon and Northwest Territories(4)	19,915	19,398	20,083	20,081	22,007	16,495	27,812	22,900
Canada	22,910	24,288	25,862	26,322	28,690	30,586	32,799	35,223

(1) Includes incidental wages and salaries.
(2) Excludes physicians employed on a salaried basis under the Cottage Hospital Medical Service and by subsidized voluntary prepayment plans. The estimated number of such excluded physicians in 1966 was 97.
(3) Excludes some physicians employed on a salaried basis in private group-practice. The estimated number of such excluded physicians in 1966 was 59.
(4) Data for the Yukon and Northwest Territories are posted for record only.

TABLE 35 - AVERAGE NET PROFESSIONAL EARNINGS(1) OF ACTIVE FEE-PRACTICE PHYSICIANS, CANADA BY PROVINCE, 1959 TO 1966

Province	1959	1960	1961	1962	1963	1964	1965	1966
	$	$	$	$	$	$	$	$
Newfoundland(2)	16,776	19,902	18,640	18,042	19,455	21,523	23,028	23,304
Prince Edward Island	11,427	12,589	13,119	15,448	15,777	16,478	17,835	18,910
Nova Scotia	14,820	16,074	16,070	15,925	15,839	17,851	19,146	20,395
New Brunswick	12,372	15,535	16,288	16,418	17,701	19,255	20,251	20,807
Quebec	11,795	12,870	14,454	15,173	16,696	18,534	20,532	21,231
Ontario	15,605	16,754	17,682	18,306	20,492	22,247	24,188	25,456
Manitoba(3)	15,442	16,000	15,829	16,742	18,178	18,720	19,681	21,565
Saskatchewan	15,096	15,955	15,843	14,619	21,625	23,879	23,530	24,274
Alberta	15,941	17,754	17,925	18,612	19,111	21,117	22,681	24,356
British Columbia	16,953	17,600	17,067	17,284	17,464	19,560	20,121	22,209
Yukon and Northwest Territories(4)	16,271	14,908	15,594	16,368	16,480	13,601	15,731	13,039
Canada	14,590	15,735	16,472	16,970	18,688	20,484	22,064	23,262

(1) Includes net professional fees after deducting expenses of practice, and wages and salaries incidental to fee practice.

(2) Excludes physicians employed on a salaried basis under the Cottage Hospital Medical Service and by subsidized voluntary prepayment plans. The estimated number of such excluded physicians in 1966 was 97.

(3) Excludes some physicians employed on a salaried basis in private group-practice. The estimated number of such excluded physicians in 1966 was 59.

(4) Data for the Yukon and Northwest Territories are posted for record only.

TABLE 36 - PHYSICIANS AND POPULATION PER PHYSICIAN, 1901-67, AND BY PROVINCE, 1967

Province	Active civilian physicians, 1967		Year	Active civilian physicians	
	Number	Population per physician		Number	Population per physician
Newfoundland	332	1,506	Census Data		
Prince Edward Island	81	1,346	1901	5,475	972
Nova Scotia	808	937	1911	7,411	970
New Brunswick	476	1,303	1921	8,706	1,008
Quebec	6,571	893	1931	10,020	1,034
Ontario	8,508	840	1941	10,723	1,072
Manitoba	1,098	877	1951	14,325	978
Saskatchewan	972	986	1961	21,290	857
Alberta	1,608	927	Register of Physicians(2)		
British Columbia	2,362	824	1951	14,163	989
			1954	15,651	977
Canada(1)	22,816	894	1959	19,300	906
			1962	21,011	881
			Number of Active Physicians(3)		
			1966	22,417	893
			1967	22,816	894

(1) Ten provinces only

(2) Department of National Health and Welfare.

(3) Source: Canadian Mailings Limited, List Catalogue, August 1967.

PART IV - NATIONAL VOLUNTARY HEALTH AND WELFARE ACTIVITIES

A number of national voluntary agencies carry on important work in the provision of health and welfare services, medical research, and education. These agencies, some of which are described below, complement the services of the federal and provincial authorities in many fields, and play a leading role in stimulating public awareness of health and welfare needs and in promoting action to meet them.

The Canadian Welfare Council. - The Council, established in 1920, is a national voluntary association of English-speaking and French-speaking organizations and individual citizens whose aim is the advancement of social welfare in Canada. Member organizations include community funds and councils, other private social agencies, various federal, provincial, and municipal departments, and citizen groups and individuals active in the fields of health, welfare, and recreation. It furnishes information, technical consultation, and field service in the main areas of social welfare and provides a means of co-operative planning and action by public and private agencies.

The policies and programs of the Council are determined by its members under the leadership of a nationally representative board of governors. With professional staff assuming executive functions, the members work together through Divisions of Family and Child Welfare, Public Welfare, Corrections, Community Funds and Councils, and Aging, and through special committees, such as the newly formed Health Aspects of Welfare. Services of the Council include public information and research. The Council publishes periodicals entitled Canadian Welfare, Bien-Être Social Canadien, and The Canadian Journal of Corrections, a directory of Canadian welfare services, pamphlets and bulletins.

The Canadian Diabetic Association. - Formed in 1953 with headquarters in Toronto, the Association has 38 branches established in nine provinces and a French-language affiliate, l'Association du Diabète, in Quebec. The aims of the organization are to promote public education regarding diabetes and the early detection of cases, to teach diabetics self-care, and to conduct research, for example, the Family Tree Research Program. The branches support various services such as free diet-counselling and summer camps for diabetic children and adults, and make available manuals and other information for diabetic patients and the public. Day centres have been established in several large cities for diagnosis, treatment, and personal health instruction.

The Canadian Red Cross Society. - Established in 1896 in Canada, the Society is affiliated with the International Red Cross and has branches in all ten provinces with national headquarters in Toronto. Its objectives, defined in its Charter, are "... in time of peace or war to carry on and assist in work for the improvement of health, the prevention of disease and the mitigation of suffering throughout the world". Thus Red Cross Society activities have been very broad, ranging from national and international disaster relief services to the support of local projects. Today its largest single activity in Canada is the operation of the national, free blood transfusion service that keeps hospitals supplied with blood provided by voluntary donors. The Society also conducts important health services including hospital and nursing outposts, an extensive homemakers service, sickroom supply loan service, and instruction in water safety and home nursing. The Junior Red Cross promotes health education through its schoolroom branches across Canada; it supports a special fund to supply treatment to needy handicapped children in Canada and a fund to promote understanding among school children of different countries.

The Canadian Rehabilitation Council for the Disabled. - This national agency situated in Toronto was formed in 1962 by the merger of the Canadian Council for Crippled Children with the Canadian Foundation for Poliomyelitis and Rehabilitation. To further its object of co-ordinating activities in all areas for the rehabilitation of the disabled, the Council works with other voluntary agencies concerned with specific disease groups or services. Examples are cerebral palsy, haemophilia and cystic fibrosis. It also carries out such functions as consultative services, public education and some research in rehabilitation. In some provinces, these two organizations have also merged to provide treatment, training, and other patient services to disabled persons of all categories. In other provinces, the handicapped-children's societies administer case-finding, restorative, and related services including parent counselling, camping and recreation; such programs are financed by Easter Seal campaigns. The foundations for the disabled in these provinces, financed by the March of Dimes or community chests, provide similar services to disabled adults with more emphasis upon vocational rehabilitation; they have been very active in the promotion and establishment of sheltered workshops.

The Victorian Order of Nurses. - Since its inception in 1897, the Victorian Order of Nurses has provided a professional home-nursing and health-counselling service to patients with any type of illness and regardless of their financial status. In all provinces except Prince Edward Island, the association's nurses carry out, under medical direction, bedside nursing with emphasis upon chronic conditions and prenatal, postnatal, and

newborn care. Most branches conduct prenatal classes and some provide part-time occupational health services to small industries. In several provinces they also assist provincial health authorities in tuberculosis and venereal disease programs and conduct child-health clinics. Through some 107 branches, V.O.N. services are available to over 60 per cent of Canada's population. A recent trend has been the extension of services to rural and semi-rural areas. The V.O.N. participates in some 17 home care programs across Canada, and directly administers nine co-ordinated home care programs. The national office is in Ottawa.

The Canadian National Institute for the Blind. - Since 1918 the Canadian National Institute for the Blind has been the national agency providing a complete social welfare service to the blind and prevention services to the visually impaired. The national office, located in Toronto, supports eight regional divisions covering all provinces and some 50 local branches serving 26,422 registered blind persons and over 136,298 prevention cases in 1967-68. Through its Eye Service, free to those in need of assistance, the Institute arranges for eye examinations and pays for medical treatment, glasses, and visual aids; it also supports the operation of a national training centre and a number of Low Vision Aid Clinics and Eye Banks in the main cities. Adjustment training, vocational, employment, recreation, and educational services and residential care for the blind are provided by Service centres and residences located in the principal cities of each province. Home teachers visit the newly blinded of all ages including pre-school-age children to teach them independence in daily living and other skills such as Braille, typing, and handicrafts. Placement officers furnish vocational counselling and arrange for training and employment. Where possible the blind are placed in jobs in general industry, in CNIB canteens, or in farming and small businesses; others are employed in the Institute's sheltered workshops. The National Library circulates Braille magazines and books and recordings and supplies a transcription service to students. The Wise Owl Club, sponsored by the Institute, promotes eye safety in industry. The E.A. Baker Foundation supports research and development in blindness prevention.

The Health League of Canada. - The Health League of Canada, first established in 1918 as the National Committee for Combating Venereal Disease, now supports a wide variety of public health education activities to prevent disease and raise health standards. The League co-operates with health departments and other national health organizations in disseminating health information. Its technical divisions are concerned with various aspects of public health such as immunization, child and maternal health, fluoridation of water, industrial health, nutrition, gerontology, and other

fields. In co-operation with its affiliates, the League administers its program from the national office in Toronto; certain branch activities for the Province of Quebec are conducted through its Montreal and Quebec offices. Educational efforts include the provision of speakers for meetings, the preparation of radio scripts, health education films, and the publication of the magazine Health and various bulletins. The League sponsors National Health Week and National Immunization Week.

The St. John Ambulance Association. - The Order of the Hospital of St. John of Jerusalem began as a local unit in Montreal in 1884 and was incorporated on a national basis in 1910 with headquarters in Ottawa. The organization, which operates through 10 Provincial Councils and serves "Special Centres", is composed of two parts -- the St. John Ambulance Association and the St. John Ambulance Brigade. The Association makes available to the public training in first aid, home nursing, and child care. Its services are used extensively by Civil Defence, Armed Forces, workmen's compensation boards, and industrial personnel, while the Brigade directs an emergency corps of trained personnel. Provincial and local units operate training courses, first aid posts, ambulance services, and other activities such as ski patrols. The Association's seven "Special Centres" are used for training purposes by several federal government agencies and private industries.

The Canadian Tuberculosis and Respiratory Disease Association. - Founded in 1900 to increase treatment facilities for tuberculosis patients, the Association's objective is the control and ultimate eradication of tuberculosis. In recent years, it has extended its interest to other respiratory diseases. The national office in Ottawa and the provincial and local branches in each province co-operate with the public health agencies in promoting adequate programs for prevention, diagnosis, treatment, and rehabilitation. The provincial associations assist in case-finding by means of mass X-ray and tuberculin-testing surveys of specific areas and higher risk groups, and carry out extensive health education work; some associations also participate in follow-up and rehabilitation of patients. Publication of educational materials and periodicals, organization of the annual Christmas Seal campaign, and research are centred in the national office. Its consultant services are available to federal and provincial health departments.

The National Cancer Institute of Canada. - The National Cancer Institute, composed of persons representing professional societies and agencies concerned with cancer research and therapy, was founded in 1947 to develop a nationally coordinated research and professional education program.

The Institute supports cancer research projects at universities, hospitals, and its own research units, maintains the Canadian Tumour Registry, provides research fellowships, and, in co-operation with the Canadian Medical Association and medical schools, promotes the post-graduate training of radiation physicists and professional education on cancer topics. It also provides an important statistical service by assisting treatment centres in designing clinical trials and developing standard data on cancer problems. The Institute receives financial support from federal-provincial grants and from the Canadian Cancer Society.

The Canadian Cancer Society. - Organized in 1938 to co-ordinate voluntary activities and disseminate knowledge in the cancer field, the Canadian Cancer Society operates in all provinces and has its national office in Toronto. Its chief services are a public education program, welfare services such as transportation, home nursing, boarding and nursing home care, sickroom supplies, and dressings to cancer patients, and the promotion of medical research through support of research facilities and fellowships for advanced study. Voluntary subscriptions to the Society provide the bulk of the funds for the Research units of the National Cancer Institute of Canada. The Society also sponsors clinical research projects in other institutions.

The Canadian Hearing Society. - Organized in 1940 as the National Society of the Deaf and the Hard of Hearing, the Society has offices in Toronto, Ottawa, London, Hamilton, and Montreal. It is concerned with the preservation of hearing, the treatment of deafness, and the rehabilitation of those with impaired hearing, including war veterans and children. It provides hearing examinations, counselling, vocational guidance, and job placement services for the deaf or hard-of-hearing, and hearing aids to persons in need. It also works closely with schools for the deaf. The Society publishes The Canadian Hearing Review and other educational material available for the public.

The Canadian Mental Health Association. - Since its organization in 1918 as the National Committee for Mental Hygiene, the Association has promoted mental health and the best possible care of the mentally ill. Its program of public education, professional and lay training, consultative services, and research is carried out by the national office in Toronto, and its provincial divisions and community branches. To develop public understanding of mental health principles, the Association sponsors discussion groups and prepares a variety of educational materials for the press, radio, and television and for professional personnel. Services to mental patients have grown rapidly as branches have established information and referral centres, volunteer

hospital visiting programs, White Cross social centres, foster-home care, sheltered workshops, and other personal services for patients and their families. Through various studies of mental health problems and the National Mental Health Research Fund, set up in 1957, the Association has stimulated new approaches to prevention and treatment in this field. A major theme stressed by the Association is the integration of mental health services with the physical and personnel resources of general medical care. The Association sponsors Mental Health Week.

The Canadian Arthritis and Rheumatism Society. - This group was formed in 1948 to help persons suffering from the rheumatic diseases by a program of treatment, research, and education. Directed from its national office in Toronto, it is organized under eight provincial divisions, and local branches in most towns. The Society has assisted many hospitals to establish arthritis clinics and, since 1960, it has supported the development of 9 rheumatic disease in-patient units at teaching hospitals. Other treatment services include home physiotherapy service available in the larger cities and mobile consultation services to patients and doctors in rural areas. The Society also supports clinical and epidemiological research projects and sponsors the regular Canadian Conference on Research in Rheumatic Diseases. Other activities include public educational services stressing early diagnosis and treatment, and the professional training of rheumatologists.

The Canadian Heart Foundation. - The Canadian Heart Foundation was formed in 1956 by physicians to co-ordinate research and disseminate information. Its membership consists of 10 affiliated provincial heart foundations and other individuals and organizations interested in promoting cardiovascular research and in public and professional education. The Foundation makes grants-in-aid to support various medical research projects and fellowship awards to promising scientists in co-operation with the medical schools and teaching hospitals. It also arranges travelling lectureships for visiting scientists. Its projects are financed by voluntary donations to the Canadian Health Fund.

The Canadian Paraplegic Association. - The Association was formed in 1945 by a group of paraplegic veterans to ensure provision of adequate treatment and rehabilitation facilities for all persons suffering paralysis caused by disease or injury. Through its national office in Toronto and eight divisional and local offices, the Association's rehabilitation program makes available physical restoration, counselling, and vocational services, prosthetic appliances, and personal aids and other activities to promote the social well-being of paraplegics.

A comprehensive service is provided at Lyndhurst Lodge Hospital in Toronto, owned by the Association; elsewhere it arranges for these services with various hospitals and other rehabilitation agencies. The Association also conducts some research including a national survey started in 1967.

The Multiple Sclerosis Society of Canada. - The Society has been organized since 1948 to support research in multiple sclerosis and allied diseases and professional training and to educate the public on the social problem of multiple sclerosis. Grants for its medical research projects and fellowships are administered from the national office in Toronto. Its five divisions and local chapters located in ten provinces raise funds mainly for research but they also provide welfare services to patients, such as friendly visiting, wheel chairs, and other personal aids. Some local chapters have undertaken patient registries. In an effort to improve patient services several Ladies' Associations for Multiple Sclerosis (LAMS) groups have been organized in a few branches.

The Canadian Association for the Mentally Retarded (prior to 1968, The Canadian Association for Retarded Children). - The Association was incorporated in 1958 to co-ordinate the work of organizations for the mentally retarded, now represented by ten provincial and over 300 local groups. The Association promotes the establishment of assessment clinics, day-training classes, sheltered workshops and activity centres, summer camps, and recreational programs. It co-ordinates and develops a national research and demonstration program through its affiliated National Institute for Mental Retardation, and supports public education of the training of workers in mental retardation. The Association is extensively engaged in the operation of special classes and sheltered workshops for trainable retarded children and adults. Financial support comes from local fund-raising campaigns, community chests, and, in varying degree, from provincial education and other departments. The national office is in Toronto.

The Muscular Dystrophy Association of Canada. - This Association was organized in 1954 to stimulate and unify research efforts into the cause, nature, and treatment of muscular dystrophy and related diseases and to promote the establishment of facilities for diagnostic, consultative, and treatment services. Under the direction of a national office in Toronto, supported by local chapters established in the main cities, its chief activity is the sponsoring of research and patient service projects in medical schools and hospitals across the country. Other activities include providing appliances and transportation to muscular dystrophy patients and supplying information to the public and professionals. Genetic counselling is being developed at several clinics.

The Canadian Cystic Fibrosis Foundation. - This national agency, organized in 1960, now has affiliated local chapters located in most provinces. Its objects are to promote special services for patients with cystic fibrosis, research, professional training, and public understanding. The Foundation has expanded its research program begun in 1962, and the distribution of educational material to parents and the general public. The national office is in Toronto.

Voluntary medical insurance. - About 11,980,000 Canadians, or 60 per cent of the population of Canada, had voluntarily secured some protection against the costs of physicians' services at the end of 1966. This protection was provided by 60 nonprofit plans with an enrolment of 6,610,000 and 80 private companies giving coverage to an estimated 5,380,000 persons. The total was 5,760,000 above the 1955 figure, which represented only 40 per cent of the population.

The nonprofit plans took in about $221,300,000 in premiums and $6,400,000 in other revenue in 1966, paid out $199,800,000 in benefits and $15,000,000 for administration, and were left with a surplus of approximately $12,800,000. Thus, for every dollar of premiums, 90 cents were paid out in benefits, which amounted to approximately $30.23 per person covered. In 1955 benefit payments had been $41,400,000, representing 89 cents of the premium dollar and amounting to $13.17 per person.

Profit-making private companies collected $167,200,000 in premiums for health protection in 1966; they paid out $132,300,000 in claims.

PART V - UNIFORM LEGISLATION GOVERNING PRIVATE PENSION PLANS

The enactment of the Canada and Quebec Pension Plans emphasized the need for uniform private pension legislation across Canada. Ontario amended the Ontario Pension Benefits Act with effect from July 30, 1965, and Quebec enacted the Supplemental Pension Plans Act with effect from July 15, 1965. The Pension Benefits Act of Alberta came into force on January 1, 1967, and that of Saskatchewan was assented to on April 1, 1967. The provincial legislation governs all pension plans operating on and after the effective date in the particular province. Similar legislation at the federal level, the Pension Benefits Standards Act, was assented to on March 23, 1967, and is applicable only to those pension plans which have any members who are employed in works, undertakings, and businesses (generally, banks and interprovincial transportation and communication) that are under federal jurisdiction.

Under these Acts, basic standards have been established with which pension funds or plans organized and administered to provide a pension benefit to employees must comply in order to receive registration, and they are not allowed to operate in these provinces or in the federal areas of responsibility unless they have received registration.

By agreement, each of the provinces mentioned above recognizes similar legislation of the others, so that a pension plan which has been registered and reports in one province does not have to seek registration or duplicate all its reporting procedures in another of these provinces if it extends its operations to employees in that other province.

The legislation requires that an employee's benefits under a pension plan become fully vested (i.e. that he has full entitlement to those benefits, which will be paid him on retirement) when he reaches 45 years of age and has completed either a minimum of ten years' membership in a pension plan or ten years' service with the one employer. Moreover, should the employee leave his job or resign his membership in the plan prior to retirement, at least 75% of his total benefits under the plan must be locked-in for purposes of his pension, allowing him to withdraw no more than 25% of the commuted value of those benefits in a lump sum.

Other provisions of this legislation are intended to ensure the full solvency of these pension plans within a specified period of time, to restrict the types of investments which may be made by the pension fund, to provide that an employee's pension rights are portable if he should change his job, and to establish that each interested party to a pension plan is adequately informed as to the provisions of the plan.

Health and welfare services in Canada